Marion Family Dental
4302 N. 76th St.
Milwaukee, WI 53222
Office 414-462-9420
Fax 414-462-9436

ACKNOWLEDGEMENT OF PAYMENT

I agree to pay any co-payment or deductible that my or my family's insurance plan requires.

I agree to pay for any treatment that I have authorized to be completed even if my or my family's insurance does not cover that service.

I am aware that any missed appointments without 24 hours notice may result in a $40.00 charge.

_____ _____

Signature Date

Relationship to Patient: _____