NORTHERN ARIZONA ENDODONTICS

Dr. Brian Kleinman

I the undersigned agree to pay in full for the services rendered at the time treatment is provided. If there is insurance to be billed, I agree to pay my co-pay quoted to me in full at the time treatment is provided. Please understand that we file insurance as a courtesy to our patients. We can only assist you in estimating your portion of the cost of treatment**. <u>We at no time guarantee what your insurance will or will not cover.</u>**

Estimated cost of my treatment is $_____

Estimated co-pay of my treatment is $_____

_____

Patient signature Date