DR. KRISTINA VINGELIS, D.D.S.
DR. TIMOTHY LEE, D.D.S.

145 Oakdale Rd.
Johnson City, NY 13790
607-217-5853

Acknowledgement of Financial Responsibility

By signing below, I acknowledge that I am ultimately responsible to pay for services rendered to myself/my child by Dr. Kristina Vingelis and/or Dr. Timothy Lee. I understand that payment is required at time of service unless prior arrangements have been made. If I have dental insurance, I have been informed that the office does not participate with any insurance, but will submit my claim as a courtesy to me and that I am responsible to pay for whatever fees my insurance does not cover. I understand that payment will also be due at the time of service unless prior arrangements have been made. I am aware that any balance that remains unpaid after 30 days will be assessed a 1.5% monthly finance charge.

I am also aware that if my account gets referred to a collection agency or commercial claims court for an unpaid balance, I will be responsible for any additional fees incurred.

Payment options: Cash, Check, Visa, Mastercard, Discover Card, American Express and Care Credit

I understand there will be a fee of $32.00 added to my account for any check returned by my bank for insufficient funds.

Patient/Guarantor Signature_____

Printed Name _____

Date_____/_____/_____