

William C. Lund D.M.D.
Cara A. Lund D.M.D.
2 Main Street, Suite 225
Stoneham, MA 02180

Patient Name: _____

Listed below are our office disclaimers. Two of the four address insurance issues, if you do not have insurance coverage than please skip to disclaimer 4, and just sign that. If you do have insurance we need you to ac knowledge all of the disclaimers.

1. I understand that my insurance is an agreement between me an my insurance Company. I also understand that I am responsible for my balance regardless of insurance coverage.
2. I assign dental benefit payments to be paid directly to Dr. William Lund, and Dr. Cara Lund from my insurance company.

Patient or Parent/Guardian Signature

Date

3. I give permission for Dr. William Lund, Dr. Cara Lund, and their clinical team to take any necessary x-rays, photos, or study models to enable complete diagnosis and treatment.
4. I understand that my account may be charge 1.5% per month or 18% per year Finance charge if any balance goes beyond 90 days.

Patient or Parent/Guardian Signature

Date