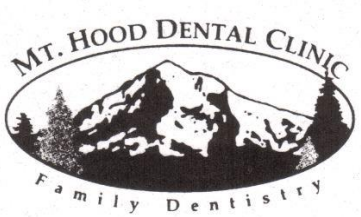

PAUL S. HANSEN, D.M.D.

Financial Agreement and Insurance Disclaimer

All payments are required at time of service unless other arrangements are made in advance.

As a courtesy to you, we will bill your insurance. However, any estimate of charges and insurance payments are subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. It is understood that the patient/responsible party agrees to be fully responsible for payment of services regardless if benefits are denied in whole or part due to eligibility or plan limitations.

I have reviewed the above statement, and understand that I am responsible for all costs of dental treatment regardless of insurance coverage. I authorize the release of any information regarding insurance claims, and hereby authorize payment directly to Paul S. Hansen D.M.D. of insurance benefits otherwise payable to me.

X_____Date_____

Signed (Patient, or responsible party)