



whitmiredmd.com  
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**ACKNOWLEDGEMENT OF FINANCIAL POLICY**

I have received, read and understand the Financial Policy of the Office  
 of *Anna F. Whitmire, DMD.*

_____	_____
Signature	Date
_____	_____
Witness	Date
_____	_____
Anna F. Whitmire, DMD	Date

***If insured:***

I understand that I am responsible for any balance that is not paid to Dr. Whitmire by my insurance company. I further understand that if my insurance company does not provide payment to Dr. Whitmire within 90 days of the claim being processed, that I am responsible for the balance on my account. I will then pursue the insurance company for reimbursement.

_____	_____
Signature	Date
_____	_____
Witness	Date
_____	_____
Anna F. Whitmire, DMD	Date