

FINANCE AGREEMENT for Dental Services

PATIENT Name: _____

Birthdate: _____

RESPONSIBLE Party's Name: _____

Home Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Relationship to patient: _____

TREATMENT PLAN: Dated _____ Estimated Fee \$ _____

**Option 1: An initial payment of \$ _____ at the first appointment, then
monthly payments of not less than \$ _____ until paid in full.**

A 1.25% monthly service charge (15% APR) will be applied to any outstanding balance.

Option 2:

I agree to option _____.

RESPONSIBLE Party signature: _____

Date: _____

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