Scott O. Kissel DMD, PC
Diplomate of The American Board of Periodontology

Financial Agreement Form

Date
Patient Name

Treatment Needed or Completed

_____
_____
_____

Treatment total $_____
Down payment $_____
Remaining balance $_____

The total installments of the remaining balance is payable in _____ monthly installments of $_____.

The first installment will be payable on __/__/__ and subsequent installments will be due on the following dates_____.

Billed directly to **Credit Card**

Credit Card Number_____ Exp date_____ CID _____
Charges to be posted on the _____day of each month.

NOTICE TO PATIENT

- Do not sign this agreement if it contains any blank spaces. You are entitled to an exact copy of any agreement you sign. You have the right at any time to pay the unpaid balance due under this agreement.
- There is no Finance Charge or Interest Charge imposed under the terms of this agreement if the agreement is kept exactly as written above. Any deviation will result in the entire unpaid balance incurring a finance charge of 1% per month (12% APR) until paid in full.

_____
Patient Signature

_____
Scott O. Kissel, D.M.D.,PC