Victoria Rd. Periodontal Associates

PAYMENT PLAN - FINANCIAL AGREEMENT

Patient Name: ________________________
Date of Birth: __/__/__
Address:______________________________
____
____
Tel: (___)___________

Doctor: Logue/Wright/Matthews

Date of Service: __/__/__
Balance Owing: $_______

Method of Payment: Visa / MC / Cheque

Weekly/ Bi-weekly / Monthly

Date	Amount	Card/Cheque Number	Date	Amount	Card/Cheque Number
Date	Amount	Card/Cheque Number	Date	Amount	Card/Cheque Number
Date	Amount	Card/Cheque Number	Date	Amount	Card/Cheque Number

I, ______________________ agree to make the payments outlined above on the balance owing and have the balance paid in full by _________________________. I understand that failure to honor this agreement will result in service and interest charges and that my account may be forwarded to Collection Services without notice.

Signature __________________________ Date __________________

Office Witness ______________________ Date __________________