PATIENT PAYMENT CONTRACT

DATE : _____

I _____ hereby agree to pay DENTISTRY AT DIPIETRO towards my dental treatment, the agreed sum of _____ on a weekly / bi-weekly / monthly basis, until my account balance is $0.00.

I understand this is a binding contract between Dentistry at DiPietro and myself, and for if any reason I cannot make this payment, I also understand that my information will be forwarded to a debit collector.

PRINT NAME (BLOCK LETTERS) : _____

PATIENT SIGNATURE : _____

STAFF NAME : _____

STAFF SIGNATURE : _____

DOCTOR STAMP : _____