Family Dentistry of West Salem

210 Leonard St. N., West Salem, WI 54669

I authorize my treatment or treatment of the patient. I agree to pay all fees for such treatment the day they are incurred, unless previous arrangements have been made. I understand that any outstanding balance is due on the date printed on the statement.

It is agreed that payments will not be delayed or withheld because of any pending insurance coverage. All proceeds of insurance are assigned to the doctor where applicable, but without the doctor assuming responsibility for the collection of those claims.

You have the opportunity to take advantage of the 10% administrative discount, if payment is received at time of your appointment by cash or check.

IMPORTANT INFORMATION: All charges are at a cash price and intended for payment within 30 days following a patient's regular billing date . If payment is not made within that period, any balance unpaid from the prior billing date will be subject to a **FINANCE CHARGE**. Below are specific conditions effective on all accounts.

1. There will be no **FINANCE CHARGE** if the account is paid prior to the second billing.
   We offer the following payment options: Cash, Check, Visa or Master Card.

2. A **FINANCE CHARGE** of 1% per month will be paid on any unpaid balance after deduction of current payments, credits and allowances from the prior billing. This **FINANCE CHARGE** is computed by a periodic rate of 1% per month. This is an **ANNUAL PERCENTAGE RATE OF 12%.**

3. We will provide you with a statement each month which shows your outstanding balance at the billing date, all payments and credits applied against the account since the last billing date, the **ANNUAL PERCENTAGE RATE** and all information listed under 2 above, plus an itemized record of all charges entered during the billing period.

4. The minimum payment required under the terms of this plan is 33.3% of the outstanding balance unless arrangements are made with your doctor.

Signature _____Date_____