

Robert W. McDowell, D.D.S., P.C.
365 Portland Avenue
Gladstone, OR 97027
503-655-4111

Payment Options

Cash, Check or Debit Card

Payment in full at **time of treatment** = 5% Discount.

Visa, MasterCard, American Express or Discover Credit Card

Payment in full at time of treatment = unable to give discount.

Financial Arrangements/Payment Plans

Monthly payments are available to a maximum 4 months. We are willing to extend this payment arrangement to you; however, our accountant requires your credit or debit card to be automatically charged each month, on a day you choose. Please complete the form below.

I authorize Robert W. McDowell, D.D.S., P.C., permission to automatically charge my credit/debit card on the _____ of each month—up to four months—for \$ _____ dollars until my balance is paid in full.

Credit or Debit _____ Card Type _____ Card Number _____
(Circle one) Expiration Date _____ V-code (on back) _____

Name as it appears on the card _____

Authorized Signature _____ Date _____

Check here if you want a receipt mailed to you. _____

**If more treatment is completed or insurance did not pay as expected, a statement will be sent to you for the remaining balance and is due upon receipt.

For Office Use Only:

Estimated Total Patient Responsibility: \$ _____

1st Payment Due Day Service is Completed _____

2nd Payment Due _____ 3rd Payment Due _____

4th Payment Due _____ (only available on amounts of \$200+)

Total amount of the bill will be due on or before _____

Installment Frequency (circle one): MONTHLY WEEKLY TWICE MONTHLY

This agreement covers only the treatment plan dated _____ for _____ and is not intended to cover additional treatment for the patient or other family members.