

Payment Options

Estimated Total Patient Responsibility \$ _____

▪ **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 this form and mail or bring it to your next appointment. Thanks.

Crown/Bridge: \$ _____ due at Prep appointment _____

1st Payment Due Day Service Completed _____

2nd Payment Due _____ 3rd Payment Due _____

4th Payment Due _____ (only available on amounts over \$200.)

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

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

Remember: paying ahead for your treatment is always an option.



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 (circle one) Card Type _____ Card Number _____
Expiration Date _____ CV code (on back) _____

Name as it appears on the card _____

Authorized Signature _____ Date _____

Check here if you would like 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.