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FINANCIAL AGREEMENT

Patient Name _____ Date _____

Financial Options: check___ cash___ credit card___ financing___

- **Payment in Full**

By check, cash or debit card at time of service

(A 5% discount will extend as a courtesy for all major treatment over \$350)

By all major Credit Cards at time of service

(A 3% discount will extend as a courtesy for all major treatment over \$350)

(BOTH EXCLUDES ALL ON 4 CASES)

- **Payment plans through Financial Partners**

(Wells Fargo, Care Credit, Chase, CitiHealth & Springstone)

6 or 12 month interest free payment plan

Can apply on our website at www.lvperio.com under (Offices)

Extended payment plan from 18 to 60 months with interest

As a courtesy to our patients, we will submit all insurance claims and pre-treatment estimates.

The investment for dental treatment is \$ _____

Initial deposit to reserve appt. time is \$ **500**

I have selected a payment option and understand my financial obligation with this office.

Patient's Signature _____ Date _____

Financial Administrator _____ Date _____