Financial Agreement for the offices of Dr. Nomith Ramdev, DMD/MSD

69 Silver St.

Dover, NH 03820

11 Hampton Rd.

Exeter, NH 03833

**⁯  6 months  12 months**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ promise to pay $\_\_\_\_\_\_\_\_\_\_\_\_ as my initial deposit

 on my surgery day. Thereafter I promise to pay the amount of $\_\_\_\_\_\_\_\_\_ monthly on

the last Thursday of every month until my invoice is paid in full. This monthly amount will

be taken directly from my debit/credit card account. If I know I will not be able to

make my monthly payment, I will call Dr. Ramdev’s office and speak with my Patient

Care Coordinator. If I fail to make my payments as stated above, I understand my

account will be given to a collection agency and I will be responsible for all additional

fees accrued.

I herby authorize Dr. Ramdev to charge my monthly fee to the credit card listed below:

Visa/MasterCard/Discover Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_

3 digit code on back of card \_\_\_\_\_\_\_ Monthly Amount to debit: $ \_\_\_\_\_\_\_\_\_\_

**Start Date:**

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Care Coordinator Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_

**If for any reason your insurance company does not pay the estimated amount you will be responsible for any remaining balance and monthly payments will be adjusted accordingly to your payment plan option. Initial \_\_\_\_\_\_\_\_\_**