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: $ _____

Patient Printed Name: _____

Patient Signature: _____

Start Date:

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 _____