R.T. CARTER, II, D.D.S

Financial & Appointment Contract

Patient's Name:_____

I understand that I am responsible for all charges for treatment of myself or above named patient.

I understand that payment in full is due at the time services are rendered; however, I agree to pay a finance charge of 1.5% per month for balances over (30) days past due.

I understand there will be a charge of $25.00 for each missed appointment without a 24 hour notice or reasonable cause.

I agree to pay all collection costs if my account is referred to a collection agency for nonpayment.

Photocopy of this contract shall be considered as valid as the original.

Signed:_____ Date:_____

(Patient or Responsible Party)