

PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial

AGREEMENT TO PAY FOR DENTAL SERVICES

Agreement to Pay. For services rendered or to be rendered to me, or to others at my request, I promise to pay to Dentist \$ _____, plus interest and other charges as stated below ("Obligations"). I will make the payments described in the payment schedule to Dentist at the address shown on the opposite side of this form.

Federally Required Disclosures. The calculations shown below are computed on the assumption that each payment will be made in full on the date due:

ITEMIZATION OF AMOUNT FINANCED

Dental Fees Down Payment Amount Financed
\$ _____ - \$ _____ = \$ _____

ANNUAL PERCENTAGE RATE	FINANCE CHARGE	Amount Financed	Total of Payments	Total Sale Price
The cost of your credit as a yearly rate. _____ %	The dollar amount the credit will cost you. \$ _____	The amount of credit provided to you or on your behalf. \$ _____	The amount you will have paid after you have made all payments as scheduled. \$ _____	The total cost of your purchase on credit, including your downpayment of \$ _____ \$ _____

Your payment schedule will be: _____ equal consecutive installments of \$ _____ each, and one final installment of _____ on the _____ day of each successive month beginning _____, 19_____.

Late Charge. If a payment is not paid on or before the 10th day after the due date, I may be charged \$10.00 or 5.00% of the unpaid amount, whichever is less.

If I pay off early, I will not have to pay a penalty, and I may be entitled to a refund of unearned finance charges.

See your contract documents for any additional information about nonpayments, default, any required repayment in full before the scheduled date, and prepayment refunds and penalties.

Other Charges. I agree to pay a charge of \$15.00 for each check presented for payment and returned unpaid. I also agree to pay all costs of collection, to the extent not prohibited under applicable provisions of the Wisconsin Consumer Act.

Application of Payments. Unless otherwise required by the Wisconsin Consumer Credit Act, payments will be applied as directed by Dentist.

Marital Information and Purpose Statement. For Wisconsin Residents Only:

I am ___ married ___ unmarried ___ legally separated. If I am married and my spouse is not signing below the name of my spouse is _____ and my spouse resides at _____ the address shown below or at _____.

If I am a married Wisconsin resident, the Obligations are being incurred in the interest of my marriage or family.

X _____

Default and Remedies. I will be in default of my Obligations under this Agreement if I have an amount outstanding which exceeds one full payment which has remained unpaid for more than 10 days after the scheduled or deferred due dates; or the first or last payment is not paid within 40 days of its due date.

In the event of default, the Dentist shall:

- A. Have all the rights and remedies provided by law and this Agreement. All remedies shall be cumulative and the exercise of one shall not prevent the exercise of any other remedies.
- B. Upon default the Dentist may, at his sole option, accelerate the amount due, without notice, unless notice and a right to cure is required by the Wisconsin Consumer Act, Wis. Stat. §425.105, and, in that event, the Obligations shall become payable after notice is provided and the right to cure has expired.

Miscellaneous.

- A. To the extent any provision of this Agreement is void or prohibited under applicable law, that provision shall be null and void and severed from the other terms of this Agreement. The remaining provisions shall be enforced to the fullest extent possible.
- B. The Dentist's waiver of one default does not waive any other default, whether the same or different, in the future.
- C. This Agreement is intended as the entire Agreement and replaces all prior and contemporaneous, written or oral, Agreements on the subject matter covered herein. The Agreement may only be modified by a written document signed by all parties to this Agreement.
- D. The terms "I", "me" and "my" includes each person who signs this Agreement, except the Dentist. If more than one person has signed this Agreement, each will be responsible for repaying the Obligations in full. Where applicable under the provisions of the Wisconsin Marital Property Act, the terms shall also apply to any non-signing spouse.
I have received a copy of this Agreement.

NOTICE TO CUSTOMER	(a) DO NOT SIGN THIS BEFORE YOU READ THE WRITING ON THE REVERSE SIDE, EVEN IF OTHERWISE ADVISED.
	(b) DO NOT SIGN THIS IF IT CONTAINS ANY BLANK SPACES.
	(c) YOU ARE ENTITLED TO AN EXACT COPY OF ANY AGREEMENT YOU SIGN.
	(d) YOU HAVE THE RIGHT AT ANY TIME TO PAY IN ADVANCE THE UNPAID BALANCE DUE UNDER THIS AGREEMENT AND YOU MAY BE ENTITLED TO A PARTIAL REFUND OF FINANCE CHARGE.

Dated _____

X _____
Patient or patient's parent or legal guardian

Dentist

• _____
Print name

By _____
Authorized Signature

X _____ /

Address: _____

• _____
Print name

Address: _____

County: _____