

Financial Agreement & Payment Plan Authorization

We understand that dental care is an important investment, and we are happy to offer payment plan options to help make treatment more manageable. Please review the agreement below.

Patient Name / ID#: _____ DOB: _____
Phone Number: _____

Payment Plan Details

Total Treatment Cost: \$ _____

Down Payment Due Today: \$ _____

Remaining Balance: \$ _____

Payment Plan Term (circle one): 3 Months / 6 Months

Payment Plan Start Date: _____

Monthly Draft Date (circle one): 1st / 15th

Monthly Payment Amount: \$ _____

Payment Method (Card on File)

Card Type (circle one): Visa / MasterCard / AmEx / Discover

Cardholder Name: _____

Card Number: _____

Expiration Date: _____ / _____ CVV: _____

Billing ZIP Code: _____

Authorization & Agreement

By signing below, I acknowledge responsibility for the payment plan outlined above. I authorize Penn Dental Arts to securely store my payment information and charge the agreed-upon amount on the selected draft date each month.

I understand that payments are processed automatically and that declined or missed payments may result in additional charges or changes to my treatment plan. I agree to contact the office if I have questions or need to discuss my account.

Patient Signature: _____ Date: _____

Witness / Front Desk Representative: _____

Signature: _____

Date: _____

Penn Dental Arts
484-821-2974
2591 Baglyos Cir.
Suite C-41
Bethlehem, PA 18020

