Richard S. Durando, D.D.S.
625 Menlo Avenue
Menlo Park, CA 94025

Financial Arrangement Agreement

Patient Name_____

Responsible Party_____

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. Please understand that clinical findings may require a change in your treatment plan, with possible changes in cost. It is our policy to make definite financial arrangements before any treatment is started.

Treatment Plan_____

_____

_____

Total Treatment Fee $_____

I agree to pay the indicated treatment fee in the following manner:

Due Date	**Amount**
_____	_____
_____	_____
_____	_____
_____	_____

Comments: _____

_____

The total fee is the patient's obligation. If you have dental insurance we will be happy to assist you in filing for direct reimbursement to you by your insurance company.

Late Fee: If your minimum payment is not received by the due date, you will be assessed a late charge of____% of the past due amount or a minimum charge of $15.

Please apply any unpaid balance due to my credit card:

Number_____ Expiration Date_____

I understand that if my account becomes delinquent, I may be put on a cash basis for myself and all members of my family for dental services.
I understand that if I leave my account in a continuous delinquent status, I may be turned over for collection. If I have any questions regarding my financial arrangements, I will call the credit manager.

Patient Signature_____ **Date**_____

Approved by _____