NUMBER_____

DATE_____

BY_____

JOHN L. BURCH DDS

FINANCIAL AGREEMENT

FOR _____

1. TOTAL AMOUNT OF TREATMENT _____
2. DEPOSIT DOWN _____
3. AMOUNT FINANCED_____
4. NUMBER OF MONTHS _____
5. MONTHLY PAYMENT _____
6. DATE OF FIRST PAYMENT _____

AGREEMENT

I agree to pay Dr. John Burch the sum of _____ in _____ equal monthly payments of _____, commencing on _____ and terminating on or around _____. Each payment will be withdrawn automatically from my credit/debit card _____ until the full amount is paid.

Signed X_____

Date_____