Randall E. Niederkohr

Board Certified Pediatric Dentist

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Payment Plan Agreement

Patient Name _____ Date _____

Responsible Party: _____

This document is to act as a set agreement for an approved payment plan based upon policy set by Dr. Randall E. Niederkohr, DDS.

The patient or responsible party listed above will agree to this payment plan as prescribed below to the patient's outstanding balance. Should the patient or responsible party deviate from the prescribed payment plan at any time (including but not limited to: missed payments, late payments, declined payments or payments not made in full) Dr. Randall E Niederkohr, DDS reserves the right to charge interest, penalties, consider delinquency, or cancel appointments at any time. **For this reason Dr. Randall E. Niederkohr, DDS requires the patient to file credit card information for automatic payments to be made as outlined by the payment plan.**

Dr. Randall E. Niederkohr, DDS is confined to deduct only the minimum payment amount as prescribed below using the patient's credit card information, unless otherwise informed by notification from the patient or responsible party.

The patient or responsible party agrees to pay Dr. Randall E. Niederkohr, DDS $_____ per month starting _____. This amount will be collected on the _____ of each month until the balance is $0.00.

Please sign and return this original document. Signature of this document denotes that all parties agrees to the terms of this agreement.

Dr. Randall E. Niederkohr, DDS: _____ CC#: _____

Patient or Responsible Party: _____ Exp. Date: _____

Date: _____ CCV: _____

Name on Card: _____