Dr. Diana Rodriguez DMD
2406 Bergenline Avenue
Union City, NJ 07087

FINANCIAL ARRANGEMENTS: For you convenience, we offer the following methods of payment.

Please check your preference:

CASH___
CHECK___
CREDIT CARD___
I wish to make financial arrangements___

Deductibles & Co-pays are due at time of service.

LATE CHARGES: If the entire balance is not paid within 25 days of date of service, a late charge of 1.5% on the unpaid balance will be assessed. There will be a $1.00 billing charge for all non-insurance billing. I realize that failure to keep this account current may result in the office being unable to provide additional services except for emergencies or where prepayment is made for services. In the case of default on payment of the account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Signature of Patient (parent if minor) _____DATE_____