Huffman And Kreger Family Dentistry, PLLC
4346 Starkey Road, Suite 3
Roanoke, VA 24018

Patient Name _____ Date of Birth ____/____/____
Last First MI M D Y

Street Address _____ Soc. Sec. #_____

City, State, Zip _____ Employer _____

Guarantor or Spouse _____ Date of Birth ____/____/____
M D Y

Street Address _____ Soc Sec. #_____

City, State, Zip _____ Employer_____

Spouse of Guarantor Name _____ Date of Birth ____/____/____
M D Y

Street Address _____ Soc Sec. #_____

City, State, Zip _____ Employer_____

Checking Account _____ Account#_____

GUARANTEE OF PAYMENT

I understand and agree to the following:

(1) The outstanding balance on my account is due and payable within thirty (30) days of the billing date as shown on my monthly statement.

(2) A monthly finance charge of one and one-half percent (18.00% APR) of the unpaid balance will be due and payable if the balance remains unpaid longer than thirty days.

(3) If it is necessary for my account to be referred to an attorney for collection there will be attorney fees of thirty three and one-third percent of the unpaid balance plus all court costs.

Date: _____ Signed _____