FINANCIAL AGREEMENT

I,_____, agree to pay the amount of $_____ to the office of Phanord & Associates, PA for dental service provided for me/and or patient I am responsible for on_____. I hereby guarantee the payment by the following date _____. I, _____, am the guarantor on this account and assume responsibility of this payment.

Payment Arrangement

I understand that unpaid accounts will be considered in default after thirty (30) days, after which time interest will be imposed at the rate of 1 ½% per month on unpaid balances (ANNUAL PERCENTAGE RAGE IS 18%) of the legal interest rate, whichever is lower. In the event a legal suit or outside collections are necessary to enforce payment of this account, I agree to pay 25% of the principle balance of attorney's fees and court costs or 30% collection fees. The patient/guarantor waives venue jurisdiction and submits itself to the jurisdiction and venue of the State Courts of Dade County, Florida.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE ABOVE AGREEEMENT AND I, THE PATIENT AND/OR RESPONSIBLE PARTY WITH THE POWER TO EXECUTE THIS DOCUMENT, ACCEPT THESE TERMS.

_____ _____

Signature of Responsible Party Date

_____ _____

Signature of Office Staff Date