



JOHN E. WILLARDSSEN, D.D.S.

California Dental Implant Center
410 ALABAMA STREET, SUITE 101
REDLANDS, CALIFORNIA 92373

(909) 307-0770

THIS IS A STATEMENT OF YOUR ACCOUNT ON THE BELOW DATE. ANY CHARGES OR PAYMENTS MADE AFTER THIS DATE WILL APPEAR ON NEXT MONTH'S STATEMENT.

ACCOUNT NO.

STATEMENT DATE

PLEASE CHARGE

☐ VISA ☐ MASTERCARD
\$

Account No.:

Security Code

3-4 NUMBERS ON BACK OF CARD

Signature of Cardholder

Exp. Date

A FINANCE CHARGE

of

% PER MONTH

equal to an

ANNUAL PERCENTAGE RATE

of

% PER ANNUM

will be added to the unpaid balance of _____ days or more past due as the billing date appearing on this statement. Payments and other credits are deducted from the Previous Balance before computing the FINANCE CHARGE.

TO INSURE PROMPT CREDIT TO YOUR ACCOUNT, PLEASE DETACH AND RETURN THIS TOP PORTION OF YOUR STATEMENT WITH YOUR PAYMENT

DATE

PROCEDURE

PATIENT NAME

DOCTOR

CHARGES

CREDITS

BALANCE

Please Pay This Amount

