



Financial Arrangement

Patient Name: _____

Treatment Plan: _____

Estimated Professional Fee: \$ _____

Estimated Insurance Payment \$ _____

Estimated Patient Portion \$ _____

Dental treatment is an excellent investment in your medical and psychological well being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we are providing the following payment options:

Payment Options

- Option A: Payment in Full
An accounting courtesy of 5% or \$_____ is given for payment in full for cash or check at the start of treatment resulting in a one time payment of \$_____.
- Option B: Visa, Mastercard, or American Express
- Option C: Monthly payment of \$_____ through Dental Fee Plan on credit approval.

I have been informed, understand and accept the treatment plan prescribed above. I understand that in some instances, unforeseen changes in treatment may be necessary and that changes in insurance coverage may vary from the estimated treatment calculation. I acknowledge that this is an ESTIMATE ONLY. I understand that I, not the insurance company, am responsible for payment in full, for ALL services rendered.

Signature (responsible party)

Date

Financial Coordinator

Date