FINANCIAL ARRANGEMENT

Date: _____ Patient's name: _____

Responsible party: _____ Daytime telephone: _____

Treatment plan total:	$ _____
Less initial payment:	$ _____
Balance:	$ _____
Less approximate insurance:	$ _____
Total amount financed:	$ _____

Payment Plan:

To be paid in _____ installments of $_____ each.

Beginning: _____

Date Due	Amount	Date Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

Sample

Patient (guardian) agrees to be and hereby is fully responsible for total payment of procedures performed in this office including any amounts which are not covered by any dental insurance or prepayment program that the patient may have. The figures in this agreement are based on a pretreatment estimate. The actual final price and/or coverage by insurance for services may vary, and the difference, if any, will be refunded or billed accordingly.

This estimate will be honored for a period of three months only from this date.

Please be advised that the policy of this office limits all accounts to terms of 30 days without a late payment charge. A late charge of _____% (_____% annual percentage rate) may be applied to all delinquent accounts.

_____ _____

Patient's (gardian's) signature Date Doctor or staff signature Date

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