

Our Financial Policy

Patient Name: _____

Date: _____

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions or assist you in any way we can.

All of our fees less than \$300 will be due and payable at the time treatment is rendered. We happily accept cash, personal checks, or credit cards (MC, Visa, American Express and Discover).

For our patients with dental insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do everything possible to see that you receive the full benefits of your policy. At no charge, we will gladly process any insurance claim for your direct reimbursement.

Payment Options

Total Treatment Estimate: _____

1. Prepayment Courtesy:

We are happy to offer a 5% accounting courtesy for all treatment over \$500 that is paid in full prior to treatment commencing.

\$ _____	Discount	\$ _____	Adjusted Total	Must Be Paid By
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2. Payment as Services are Rendered:

If you wish to pay the estimated amount for treatment at the time services are rendered we gladly accept cash, personal checks and most major credit cards.

3. Monthly Payment Plans:

“Same As Cash” Interest-Free Credit Line

Monthly Payments (up to 12 months) interest free.

\$ _____

Monthly Total

Extended Payment Plan

For treatment plans between \$1,500 & \$25,000.

18-60 months duration.

No down payment required.

Payments as low as \$59 a month.

No pre-payment penalty.

Range: \$ _____ to \$ _____

“Lay-Away” Plan

Treatment commences after comfortable monthly payments are made which equal the estimated patient portion.

I, _____, understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office.

Patient (or Responsible Party) Signature: _____

Date: _____

Financial Coordinator Signature: _____

Date: _____

Our Financial Policy

Patient Name: Janet Smith

Date: January 4, 2004

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions or assist you in any way we can.

All of our fees less than \$300 will be due and payable at the time treatment is rendered. We happily accept cash, personal checks, or credit cards (MC, Visa, American Express and Discover).

For our patients with dental insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do everything possible to see that you receive the full benefits of your policy. At no charge, we will gladly process any insurance claim for your direct reimbursement.

Payment Options

Total Treatment Estimate: \$3844

1. Prepayment Courtesy:

We are happy to offer a 5% accounting courtesy for all treatment over \$500 that is paid in full prior to treatment commencing.

\$192

Discount

\$3652

Adjusted Total

February 23, 2004

Must Be Paid By

2. Payment as Services are Rendered:

If you wish to pay the estimated amount for treatment at the time services are rendered we gladly accept cash, personal checks and most major credit cards.

3. Monthly Payment Plans:

"Same As Cash" Interest-Free Credit Line

Monthly Payments (up to 12 months) interest free.

\$320 (12/mo)

Monthly Total

Extended Payment Plan

For treatment plans between \$1,500 & \$25,000.

18-60 months duration.

No down payment required.

Payments as low as \$59 a month.

No pre-payment penalty.

Range: \$81 (48/mo) to \$185 (18/mo)

"Lay-Away" Plan

Treatment commences after comfortable monthly payments are made which equal the estimated patient portion.

I, Janet Smith, understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office.

Patient (or Responsible Party) Signature: Janet Smith

Date: January 4, 2004

Financial Coordinator Signature: Melody Johnson

Date: January 4, 2004