Financial Agreement

YOUR PRACTICE NAME (on practice letterhead)

PATIENT FINANCIAL AGREEMENT

Patient Name: _____ Date: _____

Thank you for choosing our office for your dental care. 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 and/or assist you in any way we can.

Fees less than $300 are due and payable at the time treatment is rendered. We accept cash, personal checks, or credit cards (MasterCard, 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. However, please know that we will do everything possible to see that you receive the full benefits of your current policy.

PAYMENT OPTIONS

Total Treatment Estimate: _____ **Insurance Estimate:** _____ **Patient Portion:**_____

☐ **Prepayment Courtesy:**
We are happy to offer a 5% courtesy for all treatment over $500 that is paid in full prior to the start of treatment.

$ _____ $ _____ _____
Discount Adjusted Total Must Be Paid By

☐ **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. Because we cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance payment is received. Whenever choosing this option, we ask that you leave a credit card on file for any balance that may be owed.

☐ **Monthly Payment Plans:**

☐ **Monthly Payments With Deferred Interest** (12 monthly payments)

$ _____ 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 $ _____

☐ **3 Equal Monthly Payments** – 25% initial down payment, guaranteed with major credit card

$ _____ $ _____
Down Payment Monthly Payment

I, _____, understand that any insurance 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. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

Patient (or Responsible Party) Signature:_____Date:_____

Financial Coordinator Signature: _____Date:_____