

Patient Name: _____ Consultation Date: _____

Total estimated investment for dental treatment is * \$ _____
Less estimated insurance ** \$ _____
Estimated patient responsibility \$ _____
Yearly plan maximum was and renews in \$ _____

* Total dental investment amount subject to change if unexpected treatment is necessary.

** If for any reason the estimated portion is not paid by your insurance company, it becomes your obligation.

Signature _____ Date: _____

Payment Options:

1. We accept payment with cash, check, online transfers and credit card

We accept American Express as well as other major credit cards.

Please fill in the Information below.

_____ Mo. Yr. _____
Account Number Expiration Date

_____ \$ _____
Cardmember Signature Amount Date



2. Payment in Full

An investment reduction of 5% or \$_____ is given for direct payment in full by cash or check at the start of treatment, resulting in a one-time payment of \$_____

Insured patients must file insurance for reimbursement. Our office will complete any necessary paperwork needed in the insurance process as a courtesy.

3. We offer Care Credit (www.carecredit.com) and Chase Health Advance financing options

Interest free payment plans up to 18 months

Extended payment plans for 24, 36 and 48 months at 12.96% interest

No down payment or annual fees

No prepayment penalty

(Any person using Care Credit shall request a refund of credit balance, however, this refund will reflect a deduction of our merchant discount fee)

4. Payment per appointment (Out of pocket expense less than \$250)

Based on estimates given at consultation appointment, the patient portion including your deductible (if applicable) will be due at the time of service by cash, check, or credit card.

5. Office Payment Plan (Out of pocket expense exceeding \$250.00)