

Dental Expressions Financial Arrangement Form

Dr. Robert and Dr. Heather Heil

N3946 Columbia Ave

Kaukauna, WI 54130

(920) 788-6280

Patient: _____ Date: _____

Description of Treatment:

Treatment Fee \$ _____ (estimate is valid for 90 days)
Less Estimated Insurance -- \$ _____
Patient Portion \$ _____

In our office, we do not want money to be an issue for our patients. We want you to feel comfortable with us, and that includes feeling satisfied with your financial arrangement regarding your dental care. We encourage a financial arrangement that is comfortable for you. For your ease and convenience, we offer five types of financial arrangements:

- 1) Care Credit – an outside financing company that offers 12 months interest free for any treatment over \$1000.00, pending approval
- 2) A 5% immediate payment courtesy will be given when the fee is paid in full on the day treatment begins.
- 3) We accept Visa, MasterCard, and Discover. A 5% immediate payment courtesy will be given when treatment is paid in full on the day treatment begins.
- 4) Payment may be divided into two equal payments for our patients of record. One half to be paid on the day treatment begins the remaining half to be paid when treatment is completed.
- 5) Comfortable monthly payments may be made through our billing office (90days only).

I accept Option # _____ to pay for my dental treatment.

Dental Insurance

I understand my dental insurance is a contract between the insurance carrier and me, not between Dental Expressions and the insurance carrier. Therefore, I am responsible for all dental fees. I understand I will be charged for all dental treatment and that any payments received by Dental Expressions from my insurance carrier will either be credited to my account or refunded to me if I have paid the dental fees incurred. Any fees not paid by my insurance 60 days after treatment are my responsibility.

Patient Signature

Date

Financial Coordinator