



With our convenient payment plans, simple application process and instant decisions you can schedule your treatment today and pay for it over time.

ESTIMATE YOUR MONTHLY PAYMENTS*

Use the chart below to estimate the monthly payments needed to pay off your balance(s) during the promotional period that applies to them.

TREATMENT FEE	No Interest Payment Plans		Extended Payment Plans	
	Number of Months	Estimated Monthly Payment	Number of Months	Estimated Monthly Payment
\$1,000	12	\$84	24	\$48 - \$55
\$2,000	18	\$112	24	\$94 - \$110
\$3,000	24	\$126	36	\$100 - \$125
\$4,000	24	\$168	48	\$106 - \$140
\$5,000	24	\$210	48	\$132 - \$175
\$6,000	24	\$252	48	\$158 - \$210
\$7,000	24	\$294	48	\$185 - \$244
\$8,000	24	\$336	48	\$211 - \$279
\$9,000	24	\$378	48	\$238 - \$314
\$10,000	24	\$420	48	\$264 - \$349
\$12,000	24	\$504	48	\$317 - \$419

A SIMPLE AND CONFIDENTIAL APPLICATION PROCESS.

Apply in your providers office or online at chasehealthadvance.com

FLEXIBLE, AFFORDABLE FINANCING OPTIONS

- No down payment required
- Payment plans to fit your budget
- A generous credit line for household use
- No pre-payment penalties

Extended Pay Promotional Periods of 24, 36 or 48 months will be charged at an APR of 11.99% - 25.99%. If you make a late payment or are otherwise in default, any remaining balance will accrue interest at the purchase rate of 27.99%.²

ASK ABOUT ADDITIONAL PROMOTIONS FOR TREATMENTS BETWEEN \$300 TO \$999 FOR WHICH YOU MAY QUALIFY.¹

Plus, you can use your account for any treatment including Dental, Vision Correction, Orthodontic, Hair Restoration, Cosmetic Surgery and Veterinary care at any ChaseHealthAdvance provider.

ChaseHealthAdvance™
FINANCING OPTIONS



*Payment amounts shown on the chart assume that the patient pays only the specified amount during the promotional period, with no late fees or other fees charged to the account. Payments required to fully pay off your balance(s) within the time frame allotted may vary due to your payment practices.

Provider Merchant ID #

Treatment Fee \$

Payment Plan

Estimated Minimum
Monthly Payment \$

**AFFORDABLE PAYMENT PLANS
FOR THE CARE YOU NEED**



Important: Please read carefully.

To apply, you must be at least 18 years of age (19 in NE, AL).

In most cases, you will receive a credit decision in less than 15 minutes. If we cannot approve you instantly, you will receive a call from us for clarification of application information inconsistencies or you will receive a letter in the mail from us regarding the credit decision within 7-10 days. Once your financing is approved, you have 90 days to schedule and begin treatment.

¹Check with your provider to see which plans are available. Available for purchases of \$300.00 or more. Interest will accrue during the promotional period at an APR of 24.75% to 27.99% (depending on creditworthiness). Your actual APR will be stated at the time of purchase. A Penalty Rate of 29.99% will be applicable if your minimum payment is not received within 60 days of the due date if stated at the time of purchase. Due Date Change Fee \$15. Minimum finance charge \$.50. See your Purchase Acknowledgement and ChaseHealthAdvance Revolving Account Agreement for more information about this Promotion. *Please read that material carefully.*

²Check with your provider to see which plans are available. Available for purchases of \$1000 or more. APR offered depends on credit history. A Purchase Acknowledgement will be provided at the time of purchase stating the actual APR during the promotional period. A Penalty Rate of 29.99% will be applicable to this Promotion and the account balance if your minimum payment is not received within 60 days of the due date if stated at the time of Purchase. Due Date Change Fee \$15. Minimum finance charge \$.50. See your Purchase Acknowledgement and ChaseHealthAdvance Revolving Account Agreement for more information about this Promotion. *Please read that material carefully.*

**NO INTEREST IF PAID IN FULL
WITHIN 12, 18 OR 24 MONTHS**

Interest will be charged to your account from the purchase date if the balance is not paid in full within the promotional period of 12, 18 or 24 months, you make a late payment or you are otherwise in default.¹

ChaseHealthAdvanceSM
FINANCING OPTIONS

1717 Hermitage Blvd. Tallahassee, FL 32308

www.chasehealthadvance.com

CHASE 

Credit Application

Phone:

Fax:

Patient Tracking # _____

*****3-DIGIT 342

4, 15131
Shelly McAvoy, D.D.S.
Cooper Creek Dental
Ste. 103
8640 Cooper Creek Blvd.
University Park, FL 34201

Please fill out all information completely. If you already have a ChaseHealthAdvance Revolving Account or have questions please call (888) 519-6111.

Applicant Information *(The applicant is the patient, or parent/guardian if patient is a minor)*

*First Name		*Middle Initial	*Last Name	
*Social Security #	*Date of Birth	Home Phone#	**Other Personal phone#	
*Mailing Address (including Apt #) – required				
*City	*State	*Zip	Email address	
Street Address (including Apt #) – Complete this section if the mailing address above contains a PO Box.				
City		State	Zip	
TOTAL GROSS MONTHLY HOUSEHOLD INCOME: \$ _____				
Residential Status: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Live with others <input type="checkbox"/> Other (Clarify): _____				
SOURCE OF INCOME: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Self Employed <input type="checkbox"/> Spouse <input type="checkbox"/> None <input type="checkbox"/> Other (Clarify): _____				
Alimony, child support, or separate maintenance income need not be revealed if you do not wish to have it considered as a basis for repaying this obligation. Married Wisconsin Residents: If you are applying for an individual account or a joint account with someone who is not your spouse, combine your and your spouse's information on this application.				
Present Employer		Present Employer Phone #:	Present Occupation	
Personal Reference or Relative not living with you		Relationship	Telephone	

I hereby authorize Chase Bank USA, N.A. to obtain and use information about my credit history and all information on this Application, and I authorize the release of such information to Chase Bank USA, N.A. Each applicant certifies that he/she is 18 years of age or older (19 in NE, AL). By signing this Application, I authorize any doctor or other medical provider to release to Chase Bank USA, N.A. any information and records regarding my medical or dental procedures, treatments, devices, implants and other medical or dental services and products financed by means of the ChaseHealthAdvance Revolving Account (issued by Chase Bank USA, N.A.). We comply with Section 326 of the USA Patriot Act. This law mandates that we verify certain information about you while processing your Account application. Federal law requires us to obtain, verify and record information that identifies you when you open an account. We will use your name, address, date of birth and the other information provided for this purpose. *This information is required to process your Application. The Provider (the seller of goods or services) is responsible for delivering to each applicant the ChaseHealthAdvance Revolving Account Agreement which sets forth your payment and other obligations relating to the financing of your procedures and/or purchases. **You agree that we may contact you about your account, including for customer service or collection at any address or telephone number as well as any cellular telephone number you provide us. **Ohio Residents:** The Ohio laws against discrimination require that all creditors make credit equally available to all credit-worthy customers, and that credit reporting agencies maintain separate credit histories on each individual upon request. The Ohio civil rights commission administers compliance with this law.

Name of Spouse _____ Address of spouse _____

Married Wisconsin Residents: We are required to ask you to provide the name and address of your spouse.

Applicant Signature: _____

Date: _____

Fax this form to (888)519-6222 for processing