YOUR PRACTICE NAME HERE

Address phone number, etc.

PATIENT PAYMENT AGREEMENT

Thank you for the opportunity to help you meet your oral health goals. During our discussion of your treatment recommendation and our Written Financial Policy, the following financial arrangements were made:

The cost of treatment with Dr. ___________________ is $____________. It is estimated that your insurance will cover $____________ and patient responsibility for treatment is $__________. Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. We will inform you if this occurs and you will be given the option of continuing or changing treatment. _________
(Patient initials)

I have discussed payment options and agreed upon a payment plan with the insurance company and with the undersigned provider. In the case that my insurance does not reimburse the full amount noted on the Treatment Plan, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

As you know, it is this practice's policy to receive payment prior to completion of treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. You have agreed to pay your patient portion of the treatment fee in the following way:

- Payment in full in the amount of $______________

  Paid with: _________________________________

- Deposit required: $_________________________

  Deposit paid with: ___________________________

  Remaining treatment fee: $___________________

- To be paid by: ______________ with ___________

- ___ Equal payments of $_____________________

If you have questions about your treatment plan or the choice of payment options, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)