FINANCIAL ARRANGEMENT

Practice Name

Practice Address

Practice City, State, Zip

Practice Phone #

For Professional Services Rendered or to be rendered:

PATIENT_____

TELEPHONE DAYTIME_____EVENING_____

1. Dental Investment $ _____

2. Down Payment $ _____

3. Estimated Insurance Benefit $ _____

3. Balance Due $ _____

COMMENTS:_____

_____

I understand that due to insurance policy changes and/or necessary changes in treatment plans, the amounts may vary from this estimated treatment calculation. I acknowledge that this is an **estimate only** and understand that I, not the insurance company, am ultimately responsible for payment in full for all services rendered.

I understand that all services are due to be paid in full within sixty (60) days of the date of service, whether or not my insurance benefits have been received. Should my account exceed sixty days… one and one-half percent (1.5%) interest per month (18% per year) will be charged on the remaining balance. There are no guarantees of insurance benefits. Fees quoted will be honored for 6 months.

_____ _____

Responsible Party Date Financial Coordinator Date