

Office Financial Plans

For your convenience, we ask that you choose the payment plan most suitable to your personal needs. With your cooperation, we will always strive to reach a mutual agreement and understanding.

1. Cash or Check on Date of Treatment
You will receive a 5% discount if paid in full. (10% Senior Discount)
2. Visa – Master Card – Discover on Date of Treatment
You will receive a 5% discount if paid in full. (10% Senior Discount)
3. Monthly Payment Plan *** **With Approved Credit** ***
Credit application must be approved **before** treatment is started.
4. Assignment of Insurance Benefits
Allows the Insurance to send payment directly to the office. Any estimated patient co-pay, including deductible, is to be paid on date of treatment by the patient.

I have chosen financial option: **1** **2** **3** **4**
(Please Circle your choice)

Please Read and Initial:

_____ *Discounts are not to be combined with any other offers or discounts. Payment in full must be made on date of treatment to receive discount.

_____ *I understand that I am responsible for all charges incurred, and balances remaining, regardless of insurance payments. Insurance is a contract between the patient, employer, and insurance company.

_____ *Finance charges will be applied to any account that is more than 60 days past due. Interest shall accrue from the date of the service at the rate of 1.33% monthly (16% Annually) and a minimum charge of 50 cents.

_____ *Checks that are returned for insufficient funds will have a \$25.00 fee added to the balance due.

_____ *If an appointment cannot be kept, we would appreciate 24 hours notice. Otherwise a charge of \$25.00 will be made for the broken appointment.

_____ *In case of default of payment, the undersigned promises to pay the balance due and interest that may have accrued.

***Consent:** The patient or guardian authorizes the dentist to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis for the patient. Patient or guardian authorizes the dentist to perform treatment as needed.

Signature _____ **Date** _____