(Your Letterhead)

TREATMENT PLAN ACCEPTANCE

Patient Name: _____ Date: ____/____/____
Responsible Party:_____ Relationship: _____

Treatment Plan & Financial Investment:

Patient's Full Responsibility $_____
__% Courtesy Adjustment (Investments in excess of $_____. & paid prior to the day of treatment) -
$_____ Balance (this balance includes an insurance estimate of $_____.)
$_____

FINANCIAL ARRANGEMENT

□ Cash □ Check □ DFP □ Dent Credit □Amex/Visa/MC/Disc #_____exp. date _____

(A Your investment includes outside lab costs, time and materials. This is an estimate and is valid for (60) days from the date shown above and subject to revision. Treatment requirements could be altered if *dental needs* change. The patient will be notified of any such change(s).

(B I understand that insurance estimates are *estimates only* and not a guarantee and benefits are based on my eligibility which I have verified. I also understand and accept *responsibility for any insurance claims not paid within 45 days of billing service.*

(C Treatment Plan. I acknowledge that all treatment options for my dental condition have been fully explained to me. It is my responsibility to complete treatment and follow recommended preventive maintenance schedules. If the recommended treatment and preventive maintenance plans are not followed, and/or appointments are missed, *adverse* results could affect my health and benefits coverage.

(D I am aware that Dr. _____does not make personal loans to patients for dental treatments and that unless other specific arrangements are made *beforehand*, payment is due at the time of treatment.

I have reviewed the above treatment estimate and understand that I am responsible for the ENTIRE balance and for complying with the terms of payment option I have chosen. I further understand that any balance over 45 days past due will be subject to a ___% per month (__% per annum) finance charge and that I will be liable for any attorney fees incurred in collecting any delinquent balance.

I authorize Dr. _____ to keep my signature on file and to charge my _____credit card for:
□ All visits this year □ Broken Appts/less than 24 hrs. notice □ An unpaid insurance balance over 45 days.

Patient: _____ Date: _____

□ Original/Office □ Copy to patient

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