Financial Agreement

YOUR PRACTICE NAME (on practice letterhead)

Treatment Plan Financial Agreement

Date: _____ Patient Name: _____ Treatment Plan Total: $_____

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my personal health information to carry out payment activities in conjunction with this claim.

_____ _____ $_____
Patient/Guardian Signature Date Agreement Total

Terms of Payment

☐ Other ☐ Cash ☐ Check ☐ Credit Card ☐ Debit Card

☐ Health Savings Account ☐ Third Party

***Required:** Name as it appears on card: _____

Card Type:_____ Last 4 Digits: _____ Exp. Date: ____/____

Payment Summary

Appointment Reservation: $_____ At Initial Treatment: _____

_____ I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named
(Initials) dentist or dental entity.

_____ Based upon the information provided by me, I understand that my benefit plan is anticipated to reimburse
(Initials)

$_____ for this series of visits. If by _____ my benefit plan has not paid this amount, I authorize the above referenced account be used to satisfy any remaining unpaid balance. Or I agree to resolve the balance by the date below.

Remaining Balance Due By: _____ $_____
Total Amount Paid: $_____

I agree to the above payment terms.

_____ _____
Patient/Guardian Signature Date

_____ _____
Financial Coordinator Signature Date