Easy Pay Options for Your Dental Treatment

Name: **Date:**

Treatment includes:

Total for treatment above: **$**

Estimate of insurance savings*: **$**

Total ***estimated*** patient portion: **$**

(This is an estimate based on information available to us from your dental plan. This is not a guarantee of payment)

*Dental treatment is an excellent investment in an individual's well-being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that different people had different needs in fulfilling their financial obligations, we are providing the following **EASY PAY** payments options.*

1) **Pre-payment with 5% courtesy discount:** *this discount **only** applies if paid today.*
   - Full payment of **$** by cash, check or credit card (MasterCard, Visa, American Express, Discover and FSA cards).You would **save $** if you select this option.
2) **No Down Payment Options:** *this option is subjected to credit approval and is offered by care credit, a healthcare financing company*
   - 6 months **Interest Free** (minimum $200.00):Your estimated monthly payment would be: **$** per 6 months.
   - 12 Months **Interest Free** (amounts $1,000 or higher):Your estimated monthly payment would be: **$** per 12 months
   - Over 12 months **Interest Rate 14.90%** (amounts $1,000 or higher):Your estimated monthly payment would be **$**_____________ per_______ months

3) **Multiple Payments:** *this option is only available for multiple visit procedures*.
   - **a.** **$** Down payment due today to secure my appointment
   - b. **$** Second Payment due on __________________
   - c. **$** Final Payment due at the final visit

We are committed to you for your dental treatment and we ask you for your commitment in keeping your schedule appointments. Fees are estimates only, valid for 60 days from the date shown above.

I acknowledge, that all treatment options for dental conditions have been fully explained. It is my responsibility to complete treatment and follow recommended maintenance schedules. If, I do not proceed with my treatment plan in a timely manner, maintenance plans are not followed, and/or appointments are missed, adverse results could affect my dental health. Further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth muscles or joints will be at our current fee(s).

I have reviewed and understand the above treatment estimate.

Patient Signature: ____ Date: ____________________

Financial Coordinator: ____ Date: _____________________

GREAT HILL
DENTAL PARTNERS, LLC