

**ESTIMATE OF TREATMENT FEES
 ASSIGNMENT OF INSURANCE BENEFITS
 CONSENT TO DENTAL TREATMENT**

Patient Name: _____ Parent/Guardian: _____

Address: _____ Date: _____

Telephone: _____ Dental Insurance Carrier: _____

1. Professional Fee.

<u>Service</u>	<u>Fee</u>
	\$ _____
	\$ _____
	\$ _____

The estimated fee for your recommended dental treatment is: \$ _____

This fee could vary as a result of changes made to the proposed treatment plan, but no change in the treatment plan or the corresponding fee will be implemented without obtaining your consent.

2. Dental Insurance.

If you have dental insurance, a portion of this fee will most likely be paid by that plan. Our office staff will assist you in obtaining the benefits to which you are entitled under your plan. Since you are ultimately responsible for all fees assessed, we would ask your cooperation in completing and submitting all necessary insurance forms. Dental insurance is a contract between you and your insurance carrier, not between the insurance carrier and this office. Unless you intend to pay in full for treatment as it is rendered, our office policy requires that the patient assign payment of the allowable insurance payments to _____, D.D.S./D.M.D., as specified in item 4.

If you are not covered by a dental insurance plan, our office policy requires payment in full at the time services are rendered, unless you have arranged to pay a monthly amount on your account as specified in item 3.

3. Installment Payments for Dental Services.

- 1. Total professional fee (itemized in item 1): \$ _____
- 2. Down payment on total fee: \$ _____
- 3. Unpaid balance on fee: \$ _____
- 4. Amount financed: \$ _____

- 5. Finance charge: \$ _____
- 6. Finance charge (expressed as APR): _____ % APR
- 7. Total of payments (4 + 5): \$ _____
- 8. Deferred payment price (1 + 5): \$ _____

I agree to pay the unpaid balance of the total fee to _____, D.D.S./D.M.D., in monthly installments of \$ _____, until paid in full. The first installment is payable on _____, 20____, and each subsequent payment is due on the same day of each consecutive month. Additional charges will be made for chronic appliance abuse, poor tooth-brushing habits, poor cooperation, lost or broken appliances and excessive broken appointments. If the treatment time extends beyond the original estimated date due to poor patient cooperation in any area, there will be an additional charge of \$50.00 per month. The above-quoted fees are valid for six months from date of contract. It is agreed that the doctor will continue to treat the patient as long as payment is made pursuant to this agreement. In the event payment is not made when due, or in the event of a discharge in bankruptcy, the doctor has the right to place the patient in a maintenance status and terminate further treatment.

Patient/Parent/Guardian

4. Assignment of Insurance Benefits.

I hereby authorize assignment of payment of my dental insurance benefits to _____, D.D.S./D.M.D. This Assignment of Benefits shall be deemed ongoing until my dental insurance carrier receives written notice from me that I have revoked this assignment.

Patient/Parent/Guardian

5. Authorization for Dental Services.

I hereby authorize the performance of the dental services listed in item 1 above and I consent to the performance and/or administration of the dental procedures and medications deemed necessary by _____, D.D.S./D.M.D. to complete this treatment.

Patient/Parent/Guardian