Financial Agreement Form

Patient Name: _____ Scheduled Appointments:
_____

Date of Pre-Authorization: _____/_____/_____ Insurance Company:
_____

Type of Treatment Rendered
_____

Total Fee: $_____

Insurance estimated payment: $ _____

Insurance Adjustment: $_____

Patient estimated responsibility: $ _____

☐ **Option A**
Payment made at time of service $_____ (with10% discount)_____

**When co-payment is greater than $500.00 a 10% pre-payment courtesy will be available when payment is made in full at treatment start with a check and or cash. This cannot apply to those receiving other discounts, such as InHouse Discount Plan.*

☐ **Option B –** Payments divided up over 3 payments
Date: _____/_____/_____ $ _____ Balance $_____ 50%
Date: _____/_____/_____ $ _____ Balance $_____ 25%
Date: _____/_____/_____ $ _____ Balance $_____ 25%

☐ **Option C – Care Credit** application for payment plan. Payment is due at time of service (minimum $300, interest free)
Total Estimated Patient Balance: $_____
Est. Monthly Payment: $_____

☐ **Option D – Debit Card:**

Est. Monthly Payment $ _____
Date: _____/_____/_____ $ _____ Balance $_____ 33.3%
Date: _____/_____/_____ $ _____ Balance $_____ 33.3%
Date: _____/_____/_____ $ _____ Balance $_____ 33.3%

Signature of Cardholder _____

Option E –Credit Card Authorization
I hereby authorize my credit card to be charged for the above amounts on the above stated dates, in order to complete payment of the written fees (card authorization with information on separate form)
Date: _____/_____/_____ $ _____ Balance $_____ 33.3%
Date: _____/_____/_____ $ _____ Balance $_____ 33.3%
Date: _____/_____/_____ $ _____ Balance $_____ 33.3%

I understand that I am responsible for all fees incurred for the above treatment and agree to pay according to the option I have chosen. I realize I am responsible for the remaining balance. **Any account balance that becomes delinquent over sixty days after this agreement will incur a 20% finance charge. Additional charges may occur if the account is turned over for collection.**

Signature ____ Date ____________________________________