

Apollonia Dental Center

INFORMED CONSENT (financial options)

Patient's name _____ Date _____

Total Case Fee: \$ _____

Estimated Insurance Payment

Because insurance companies historically underpay most claims, we calculate our estimates based on actual payment history. We do not base our estimates on what an insurance company tells the patient they will cover in their sales literature and policy brochures.

\$ _____

Patient Responsibility (after estimated after insurance payment): \$ _____

We have expanded our financial options to make paying for needed dental care even easier and more convenient than ever before. Please indicate your choice of the following four payment options:

- Cash, check or credit card for the full treatment plan at commencement of treatment. An 5% administrative courtesy is extended.
- Private financing is available for our patients who qualify through our own In-House Financing Company. Applications and details may be obtained from our Patient Financial Coordinator. This option may be interest free for 12 months. Example: on a balance of \$5,000 the monthly payment can be as low as \$115 per month.
- Insurance benefits may be assigned for direct payment to us, with pre-payment of your estimated share for the full treatment plan at commencement of treatment. An automatic charge will be made to your credit card for any remaining balance after insurance payment, where applicable.

Credit Card # (if applicable) _____
Type (please circle): VISA MasterCard AmEx Discover

- At each visit for you (or an authorized family member), we will automatic charge the fee for that visit to your credit card.

Credit Card # (if applicable) _____
Type (please circle): VISA MasterCard AmEx Discover

Please feel free to ask us for clarification of our stated options.

Patient's signature / Date

Staff signature / Date

INFORMED CONSENT FOR FINANCIAL OPTIONS