

CARE PLAN PAYMENT OPTIONS

Patient Name _____ Date _____

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

Please check the box of the option best suited to your financial needs, and initial your choice on the line provided.

Care plan for treatment of: _____

The fee for care plan presented \$ _____

Less estimated insurance* \$ _____

Patient estimated responsibility \$ _____

Option 1: Payment in Full (by Check or Cash) for treatment over \$1000.00 _____ (Initial)

A bookkeeping courtesy of **5%** or \$ _____ is given for direct payment in full at start of treatment by cash or check resulting in a **one-time** payment of _____. (If applicable, dental insurance claims will be filed on your behalf and you will receive the insurance reimbursement.)

Option 2: Payment in Full (by Credit Card) _____ (Initial)

Payment may be made in full using one or more Visa, MasterCard, Discover or American Express credit cards. A bookkeeping courtesy of **2.9%** or \$ _____ is given for payment in full with credit card at the start of treatment, resulting in a one time payment of \$ _____. (If applicable, dental insurance claims will be filed on your behalf and you will receive the insurance reimbursement.)

Option 3: Chase (only up to 48 months) & CareCredit (up to 60 months) _____ (Initial)

- No initial payment
- Payment plans up to 60 months on CareCredit
- Payment plans up to 48 months through Chase (for treatment \$4000+)

3Months _____ **6 Months** _____ **12Months** _____ **(NO INTEREST Plans)**

24Mo _____ **36Mo** _____ **48Mo** _____ **60Mo** _____ **(13.9% Interest Plans)**

I _____ give Dyer Family Dentistry authorization to obtain a credit report on myself for the purpose of extending credit options for treatment.

(Patient Signature)

(Date)

I have read and understand the office financial policy. ***Regardless of insurance coverage, I am responsible for payment of all dental fees for myself and/or my dependents.*** There is no guarantee of refund based on treatment outcome. I authorize Dyer family Dentistry to furnish information to insurance carriers concerning my or my dependents dental treatment.

SIGNATURE _____

DATE _____

*If for any reason the estimated amount is not paid by your insurance, it is your obligation to fulfill payment within 60 days.

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