

# 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.