WISPELWEY DENTAL
FAMILY, COSMETIC & IMPLANT DENTISTRY

TREATMENT PAYMENT AGREEMENT FORM

One agreement is good for each patient and is valid until you request and update the financial agreement.
Payment arrangements ar required at the time of scheduling your appointment.

Date _____ Patient Name _____

Total TXP $ _____ Estimated of Out of Pocket $ _____

WE OFFER THE FOLLOWING PAYMENT OPTIONS

(please choose one)

❒ **PAYMENT AT THE TIME OF SERVICE** (We accept Cash, Check, MasterCard, Visa, Discover and American Express) **entire out of pocket estimate for services rendered is due the day of treatment.

❒ 5**% PREPAYMENT DISCOUNT FOR PAYMENT IN FULL** (this is offered payments for the full out of pocket amount for the entire treatment plan 72 hours prior to the first appointment)

❒ **INTEREST FREE FINANCING** (up to 18 months interest free financing depending on amount financed upon approval from CareCredit)

This is an estimate only of treatment diagnosed based on clinical and x-ray examination. You have been presented with the risks, benefits and alternative of this treatment. All your questions have been answered.

Your agreement with the insurance company is between you and your insurance company. We are happy to file necessary forms to insure that you receive the full benefits of your policy, but make no guarantee of payments or any estimated coverage. You will be responsible for any balances not covered by insurance.

I hereby certify that I have fully read the above and agree with all the terms and conditions.

Patient Signature _____ Date _____