

Practice Name & Logo

Doctors Name

Address

City, St. Zip

Telephone

Date: _____

Patient Name: _____

Treatment Recommended:

Estimated Investment:

\$ _____

Initial Payment:

\$ _____

Dr. _____ has informed me of my recommended dental treatment and the associated investment. My questions regarding my dental treatment and possible risks involved have been answered to my satisfaction. I understand, as explained to me, that dental care recommendations are subject to change as treatment progresses due to unforeseen complexities. These changes can alter the total investment costs of this treatment plan. I acknowledge the employee benefit may not cover the cost of my treatment. I agree that I am responsible for my account and accept the treatment and investment stated on this document. In the event my employee benefit has not paid with-in 30 days I agree to pay the account in full. I understand my employee benefit coverage including any deductibles and that they may not be included in this quote. Accounts outstanding over 30 days will be accessed a finance charge of ____% monthly
This quote is effective for 90 days.

Signature-Patient/Parent/Guardian

Date

Signature-Financial Coordinator

Date