

Ace Dental
713 Hebron Parkway Suite 216
Lewisville, TX 75057

PATIENT PAYMENT AGREEMENT

Thank you for the opportunity to help you meet your oral health goals. During our discussion of your treatment recommendation, the following financial arrangements were made:

The cost of treatment with Dr. Reddy is \$_____. It is estimated that your insurance will cover \$_____ and patient responsibility for treatment is \$_____. Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. We will inform you if this occurs and you will be given the option of continuing or changing treatment. _____

(Patient initials)

I have discussed payment options and agreed upon a payment plan with the insurance company and with the undersigned provider. In the case that my insurance does not reimburse the full amount noted on the Treatment Plan, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

As you know, it is this practice's policy to receive payment prior to completion of treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. You have agreed to pay your patient portion of the treatment fee in the following way:

Payment in full in the amount of \$_____

Paid with: _____

Deposit required: \$_____

Deposit paid with: _____

Remaining treatment fee: \$_____

To be paid by: _____ with _____

_____ Equal payments of \$_____

If you have questions about your treatment plan or the choice of payment options, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)