United Dental Services PLLC

361 Main Street | JOHNSON CITY NY, 13790 | (607) 773-3131

Patient Payment Agreement

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

The estimated cost for your 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)

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, you will receive a refund less the cost of care received. It is estimated that your insurance will cover $_____. 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: $_____

☐ ___ 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.

We look forward to seeing you at your scheduled appointment at _____ on _____.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)