Gary R. Folkman D.D.S.,P.S.
P.O. Box 108
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(425)392-5602
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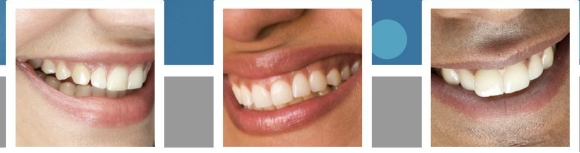

FINANCIAL OPTIONS & ARRANGEMENTS

Date:

Patient:

Description of Treatment:

Insurance Estimate:

Estimated Patient Balance:

Your dental health is our top priority. The purpose of this letter is to provide you with an estimate of fees for the dental services recommended by Dr. Gary Folkman. Please understand that this is only an estimate. The course of treatment may need to change for a variety of unforeseen reasons. Every effort will be made to inform you if a change in treatment becomes necessary.

With regard to estimating the patient balance for those with insurance, we would like to stress that we are only able to provide an estimate based on the information provided to our office by you and/or your dental plan. Limitations and exclusions may exist in your dental plan that has not been disclosed to our office by your dental carrier. If your dental plan pays more than expected, you will receive a prompt refund. If your dental plan pays less than expected, a balance due will be reflected on your monthly statement. If eligibility is denied, the full balance becomes your responsibility.

To assist you in proceeding with treatment, we offer several payment options. Please indicate which option you prefer.

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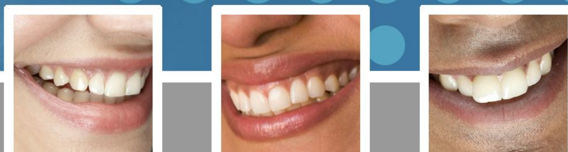

PAYMENT OPTIONS:

___Plan A: Same Day Payment Courtesy
A 5% discount is offered when treatment is paid in full day at the time of treatment.

Discount $_______________ Patient Due $________________

___ Plan B: Two Equal Payments
For treatment involving lab services, payments can be divided into two equal payments. One half is due the day of treatment is started, and other half is due when treatment is completed.

___ Plan C: Monthly Payment Plan:
For patients who prefer to make monthly payments, we offer short- and long-term financing through an outside healthcare financing company (Citi Health Card). Please let us know if you would like information about this option.

FINANCIAL RESPONSIBILITY AND AGREEMENT:

I, ______________________________________, have chosen Payment Plan _______ above.
I understand that any dental plan I have is strictly a contract between myself and my insurance carrier. As such, I agree to be responsible for full payment of all dental services not paid in full within 45 days regardless of dental benefits estimated above.

__________________________________ __________________________________
Patient/Guardian Signature Date Authorized Staff Signature Date

Response Date: [ ]