dentalarts
Cosmetic & General Dentistry

Financial Arrangements

Patient _____ Date _____

Diagnosed Treatment

Treatment Total _____

Estimated Patient Portion _____

Financial Options

	Down Payment	Payment
☐ Check or Major Credit Card		$0.00
☐ Dental Arts Payment Plan*		
□ 3 Months No Interest	N/A	N/A
□ 6 Months	N/A	N/A
☐ Compassionate Healthcare Services	Down Payment	Est Payment
□ 12 Months	N/A	N/A
□ 24 Months	N/A	N/A
☐ Care Credit		
□ 36 Months		Not Applicable

*Auto drafts via credit or debit card

Notes

I acknowledge that all treatment options for my dental condition have been fully explained to me. It is my responsibility to complete treatment and follow recommended maintenance schedules. If I do not proceed with my treatment plan in a timely manner, maintenance plans are not followed and/or appointments are missed, adverse results could effect my dental health. Further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscle or joints will be based on our standard professional fees.

For our patients with dental insurance, we are pleased with the care you have selected. Your insurance coverage is a contract between you and your insurance company. Our professional services are rendered to you and not to your insurance company. Therefore, you are directly responsible to us for the obligation of payment for treatment. We will do our utmost to help you maximize the benefits which you are entitled to.

_____ _____

Patient Signature Date

8304 Creedmoor Road ● Raleigh, NC 27613 ● (919) 870-7645 ● Fax (919) 870-8931