CONNECTICUT FAMILY DENTAL
SERVING THE GREATER WATERBURY AREA
203.574.2725 • CTFDENTAL.COM
171 GRANDVIEW AVE. • SUITE 103 • WATERBURY, CT 06708

Payment Options For Your Care

Patient Name: *John Doe* Date: *January 1, 2014*
9876

Needed Dental Care

Treatment Plan
White Fillings: Teeth# 28, 29, 3, 4, 5
Zoom Advanced Whitening
Porcelain Crowns: Teeth# 8, 9

Total charges: *$2,765.00*
**Estimated insurance payment:* *$2,000.00*
Your unused insurance payment dollars run out in:* **364** ***days*

*** Estimated Patient Portion: $765.00**

Payment Options

Extended Monthly Payment Plan	☐ **$50.20**	per month for 12 months, with credit approval, 12% APR Initial down payment made 3 days before appointment: $200.00 Remainder financed over 12 months: $565.00
Regular Monthly Payment Plan	☐ **$200.81**	per month for 4 months, includes a 5% management charge First monthly payment made 3 days before appointment.
Pre-Payment in Full	☐ **$765.00**	pre-payment with cash or check today, or credit card charged 3 days before appointment.

Credit Card On File Last 4 Digits: _____ Expiration: _____

* I authorize my insurance company to make payments directly to this dental office for benefits. I understand that I am responsible for all charges whether or not they are covered by insurance. I authorize this office to credit or charge my credit card for any balances or credits resulting after insurance payments have been processed.

If such charge over $100.00 is necessary, I require this office to notify me before the charge is made. I fully understand that quoted costs are estimates only, and the patient portion will change if changes are made to the treatment plan or if insurance pays more or less than estimated.

Patient / Guarantor _____ Date _____ Financial Coordinator _____