**Treatment Plan**

Date:

Prepared for:

Procedure(s):

Total Fee:

Estimated insurance payment:

Estimated patient payment:

I realize that it is my responsibility to understand my insurance benefits. I also understand that my insurance will be billed as a courtesy to me.

The percentage of the balance normally not covered by the insurance company is due on the day of consult and/or treatment. We have no way of knowing exactly what the insurance will pay without prior written authorization, which may take 4-6 weeks. You will be responsible for any services not paid by your insurance company. You should contact your insurance company regarding any delay in processing your claim. Please remember, this is just an estimate.

I realize that making an appointment for treatment requires the practice to prepare and set aside time for my care. I agree to confirm and keep my appointments and to notify the practice of any changes 48 hours in advance or incur a $50 missed appointment fee.

I understand and agree to the above treatment plan, estimate, and office policy. I have reviewed the treatment plan and authorize release of any information relating to this claim. I understand that I am responsible for all cost of dental treatment.

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Patient or Responsible Party Date