CASTLE HILLS FAMILY DENTAL

Rafael L. Mercado, DDS, PLLC
1931 NW Military Hwy Suite #225
Castle Hills, Texas 78213
(210)732-4570 phone
(210)732-4572 fax

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, your refund will be determined upon review of your case. It is estimated that your insurance will cover $_____. You agree that any anticipated payments not made by your insurance plan will become your responsibility.

You have agreed to pay your patient portion of the treatment fee in the following way:

q Payment in full in the amount of $_____

Paid with: _____

q Deposit required: $_____

Estimated Insurance:$_____

Discount: $_____

Remaining treatment fee: $_____

___ equal payments of $_____

and a final payment of $ _____

For Orthodontic patients: _____
(Patient initials)

You agree to pay all installments on a monthly basis with a credit card on file (regardless if an appointment is made or kept). Treatment is estimated to take _____ months and at least one year retention. The Orthodontic fee includes all Ortho related x-rays, impressions, and records taken once treatment has commenced. Orthodontic fee does not include the original records, general dentistry, fillings, extractions, and examinations for cavities, etc. You understand that treatment will be discontinued without refund for lack of patient cooperation or failure to comply with the treatment plan.

For Payment Option: _____
(Patient initials)

Your credit card will be run on the same day every month. If the payment falls on a weekend or holiday, it will be run on the next business day, with no late fee. If a payment is held at your request past the due date, there is a $10.00 late fee. There is a $25.00 NSF fee for all declined transactions.

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)

_____
Witness Date