(209) 522-8800

Patient Name: Charles Brown   Presented by: Tiger Woods   Date: 8/26/2013

Summary of Treatment Plan:
White fillings teeth #18-MOD, 19-DO
Porcelain crowns teeth #14, 15, 30, 31

If you don't use your insurance benefits, they run out in 125 days.

Total fee: $1,000.00

Possible insurance benefits to be paid and any other down payment: $0.00

Total due after insurance: **$1,000.00**

Option	Details		
Save Money	**Pay in full cash or check, 10% discount** (only for amounts >$1,500)	You save: **$100.00**	You pay: **$900.00**
2-3 Equal Payments	**Half now & half next appointment** or **90 days same as cash**	2 equal payments of:	**$500.00**
		3 equal payments of:	**$333.33**
No Down Payment & 0% Interest	**Care Credit™** (patients with healthy credit)	0% interest with 6 monthly payments of:	**$166.67**
		0% interest with 12 monthly payments of:	**$75.00**
Most Affordable & Easy Approval	**Compassionate Healthcare Services™** (most patients approved) Request a monthly payment: Initial downpayment due at the time of scheduling.	Remaining down payment required:	**$200.00**
		(Amounts < $1,750) Payments starting at:	**$71.79**
		(Amounts > $1,750) Payments starting at:	-

I Choose:

- ☐ Save Money
- ☐ Half now & half at next visit
- ☐ 90 days same as cash
- ☐ Care Credit™
- ☐ Compassionate Healthcare Services™

$__________________ per month

Notes:

Important: I understand that the amount due is my responsibility and that insurance is billed as a courtesy to assist me in paying my obligation. I understand that insurance figures provided are estimates only. If the insurance company pays more, I will receive a refund. If the insurance company pays less, I will receive a bill for the difference. I understand that if my insurance company fails to pay within 60 days of the claim being submitted, the full amount due is my responsibility and I will make payment in full. I understand that the above estimated fees are based on my treatment plan as listed above. The treatment plan may change, altering the total cost of care.

Patient (or responsible party) Signature ____________________   Date ____________