

Fee Estimate and Payment Options

Patient name

Original date of service

Thank you for choosing our office for your endodontic treatment. Please review your fee estimate below. **Fees are due when treatment is complete.** If you have questions, please ask our front desk before treatment.

Tooth #	Treatment proposed	ADA code	Fee

Total fee

Estimated insurance payment or discount

YOUR ESTIMATED PORTION (due at time of treatment)

Save with cash or check

Prices above are card prices. **Pay in full with cash or check at the time of treatment and save 3.5%.**

ABOUT INSURANCE

This is our best estimate. Because we do not hold your insurance contract, the amount your insurance pays may be different.

Payment for endodontic services is the patient's responsibility. We cannot provide services on the assumption that insurance will pay.

LATE PAYMENTS

Cottonwood Endodontics, P.C. may charge a late fee of 18% per year on amounts not paid on time. If an account is sent to a collection agency, the patient or responsible party will be responsible for all collection fees and costs, including reasonable legal fees needed to collect the remaining balance.

I have reviewed the office financial policy and federal Truth-in-Lending statement on the back of this form.

Signature

Date

Relationship to patient

Office Financial Policy and Federal Truth-in-Lending Statement

PAYMENT ARRANGEMENTS

As a condition of treatment, financial arrangements must be made **before** treatment. Our practice depends on payment from patients to cover the cost of their care. Emergency services, and any services provided without arrangements made in advance, must be paid by cash or credit card at the time of service.

DENTAL INSURANCE

All services are charged directly to the patient, and the patient is personally responsible for payment. We will help prepare your insurance forms and help collect from your insurance company, and we will credit any insurance payments to your account. However, we cannot provide services on the assumption that insurance will pay in full.

SERVICE CHARGES

A monthly service charge of **1.5% per month (18% per year)** on the unpaid balance as of the last day of each month will be added to accounts more than **60 days** past the date of service, unless written arrangements were made in advance. Fee estimates are valid for **6 months** from the date of your exam.

MY AGREEMENT TO PAY

In return for the services provided to me (or, at my request, to my minor child or ward), I agree to pay the fees charged at the time services are provided. If my account becomes past due, I agree to pay the remaining balance plus the collection agency's fee, reasonable attorney fees, and court costs where legal services are needed. I authorize the release of financial information about my account (charges, payments, interest, etc.) to the collection agency or attorney if collection becomes necessary.

CONTACTING ME

You or your representative may call me at home or at work about matters related to this form. You may leave messages about appointments and/or results on my voicemail or with a family member.

SHARING INFORMATION WITH MY INSURANCE

I authorize the dentist or his designee to release financial information and treatment descriptions, electronically, by fax, or on paper, to my insurance carrier or any related entity that requires it.

PRIVACY

I acknowledge that I have reviewed a copy of this office's Privacy Policies. I agree to tell the dentist the names of anyone with whom I allow him to discuss my dental care.

PAYMENT POLICY: CASH DISCOUNT

Our standard prices are card prices. Patients who pay with **cash or check at the time of service receive a 3.5% discount** off the standard price. The discount is applied automatically at checkout when a qualifying payment method is used. **This is not a surcharge.** For details on how your payment information is handled by our processor, visit <https://dentalpay.ai/>.

Certification

I certify that I have answered all questions about finances accurately and to the best of my knowledge, and I agree to the conditions described above.