

PATIENT NUMBER

© 2001 Wisconsin Dental Association  
(800) 243-4675

PATIENT'S NAME \_\_\_\_\_  
Last First Initial

I \_\_\_\_\_ have had my treatment plan and options explained to me and hereby  
authorize this treatment to be performed by Dr. \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian MUST sign if patient is a minor)

I also understand that the cost of this treatment is as follows and that the method of paying for the same  
will be:

|                                       |                 |
|---------------------------------------|-----------------|
| Total (Partial) estimate of treatment | \$ _____        |
| Less:                                 |                 |
| Initial Payment                       | — _____         |
| Insurance Estimate if Applicable      | — _____         |
| Other _____                           | — _____         |
| <b>Balance of Estimate Due</b>        | <b>\$ _____</b> |

Terms: Monthly Payment \$ \_\_\_\_\_ over a \_\_\_\_\_ month period.

PLEASE CONTACT THE BUSINESS OFFICE IF YOU ARE UNABLE TO MEET YOUR FINANCIAL OBLIGATION

The truth in lending Law enacted in 1969 serves to inform the borrowers and installment purchasers of the true Annual Interest charged on the amounts financed. This law applies to this office whenever the office extends the courtesy of Installment Payments to our patients, even when no finance charge is made.

The signature below indicate a mutual understanding of the ESTIMATE for treatment and the acceptable schedule of payment as noted.

Today's Date \_\_\_\_\_  
Signature of Responsible Party \_\_\_\_\_

Financial Advisor

Phone Number

Note: THIS IS AN ESTIMATE ONLY, if treatment plan should change please request an amended estimate should it not be offered by our staff. This estimate is valid for 90 days from the date above IF treatment has not begun within that period. A patient's voluntary termination of treatment makes this agreement invalid.