Island View Dental
638 North Webb Road
Grand Island, NE 68803
(308)381-0167 / Fax (308)381-6689

PATIENT PAYMENT AGREEMENT

Patient Name:_____ Date:_____

Total Treatment Amount: $_____

Option 1:
Total patient responsibility paid at time of service by cash, check, or credit/debit card.

Option 2:
½ of total fee paid at treatment date Amount_____Date_____
Remaining ½ of total fee next month Amount_____Date_____
CREDIT/DEBIT CARD #_____Exp Date_____ VCode_____

Option 3:
1/3 of total fee at first treatment date Amount_____Date_____
1/3 of total fee next month Amount_____Date_____
1/3 of total fee 2nd month Amount_____Date_____
CREDIT/DEBIT CARD #_____Exp Date_____VCode_____

Option 4:
CARE CREDIT- No interest if paid in full within promotional period of 6 or 12 months. (*$200 minimum)*
Extended payment options 14.9% APR 24, 36, or 48 months (*$1,000.00 minimum*) or 16.9% APR 60 months. (*$2,500.00 minimum)*

IMPORTANT: Practice will submit insurance for patient reimbursement. ***Insurance portion is an estimated amount.*** Payment may vary based upon the patient's deductible and plan limitations.

This is to certify the above treatment fees and checked payment option has been explained to me and I fully understand the nature of the treatment recommended***. I understand and agree that if my insurance does not pay my insurance claim within 45 days, I am responsible for any balance due.*** I agree to pay reasonable attorney's fees, court costs and collection costs incurred by Island View Dental in collection and enforcement of the debt. The above fees will be honored for 6 months or until commencement of treatment, whichever occurs first.

Accepted:_____ Date: _____

Financial Coordinator: _____