Deborah A. Struckmeier, D.M.D.
4611 N.E. 102nd Ave.
Portland, OR. 97220
503-255-1151

PATIENT PAYMENT OPTIONS

Patient Name:_____ **Initial Date:**_____

Treatment:_____

_____**Pre-Payment for entire treatment plan**

*Practice will submit insurance for patient reimbursement

_____**Pay as you go for each treatment**

*Total paid at time of treatment by cash, check or credit card

_____**1/2--1/2**

*1/2 of total fee at first treatment Amount:_____ Date:_____

*Remaining 1/2 of total fee at final treatment Amount:_____ Date:_____

_____**1/3--1/3--1/3**

*1/3 payment at first treatment Amount:_____ Date:_____

*1/3 payment at final treatment Amount:_____ Date:_____

*1/3 payment on final treatment Amount:_____ Date:_____

with post dated check or credit card voucher

DENTAL FEE PLAN OPTIONS

_____**Payments over several months**

*0% financing for 3 months, 6 months or 12 months

*Practice pays the interest for one year $_____monthly payment for _____months.

_____**Extended payment option**

*The above company also offers 24 thru 60 month payment plans

*Patient pays all interest

Total itemized fee $_____

Estimated Insurance Portion $_____

Total $_____

Deductible $_____

Estimated Patient Portion $_____

IMPORTANT: Insurance portion is an estimated amount. Payment may vary based upon my deductible and plan limitations.

*I understand that insurance is billed as a courtesy to our patients, that insurance estimates are very difficult to calculate in advance of processing an actual claim, and that Deborah A. Struckmeier, DMD is not bound by the rough insurance estimates above.

*I understand that my insurance contract is between me and my insurance company.

***I am fully responsible for all charges for dental services and agree to pay in full any balance not paid by my insurance company within 60 days of the date each service is rendered.**

*I agree to pay a service fee computed at the rate of 18% per annum on any outstanding balance over 90 days from the date of service.

*I agree to give your office 48 hours notice for any appointment I cancel. If I fail to give you this notice, I agree to pay a missed appointment fee of $60.00 within 30 days.

This is to certify the above treatment fees and checked payment option have been explained to me, and I fully understand and accept the nature of the treatment recommended. I agree to pay reasonable attorney fees, court costs and collection costs incurred by Deborah A. Struckmeier, D.M.D. in collection and enforcement of the debt.

CONFIDENTIAL

Signature:_____ Date:_____