FEE ESTIMATE AND PAYMENT AGREEMENT

- Payment is due at the time of service.
- Total treatment fees and the amount due on the day of the appointment can vary due to occasional changes in treatment during the procedure. Please bear in mind that any estimates made prior to treatment or by phone are subject to change. Your final payment amount will be determined once all treatment is completed.
- If you are covered by insurance, please be aware that most insurance plans do not cover the entire cost of your dental treatment. Only a percentage (50-80%) of what the insurance companies are willing to pay for a particular procedure is paid. What the insurance companies are willing to pay is frequently much lower than the actual cost of the treatment.
- As a courtesy, we will file your insurance for you at no charge, but please remember that your insurance contract is between you and your insurance carrier. Payment for treatment is your responsibility. You are responsible for the entire charged amount regardless of your insurance benefits.
- Once insurance benefits have been received the **ENTIRE REMAINING BALANCE** is due **IN FULL** within 30 days upon receipt of statement; otherwise the account will be turned over to our professional collection agency.
- Please do not hesitate to inquire about our payment options.
- NSF checks are subject to a $25.00 service charge.

How will you settle your payment today? (Please check one below)

__CASH/CHECK ___DEBIT ___CREDIT CARD ___FINANCING

Standard Fees

Consultation w/CBCT scan- $175

Root Canals: Anterior- $815
Premolar- $915
Molar- $1,020

Root Canal Retreatment: Anterior- $980
Premolar- $1,080
Molar- $1,185

- Circumstances may arise that warrant additional fees

(For example: fillings, post placement, soft tissue removal and emergency treatments)

I hereby authorize payment of the dental insurance benefits, otherwise payable to me, directly to Joshua D. Beaver, DDS, and LLC, if applicable.
I understand that any remaining balance on my account must be paid within 30 days of the date of the initial billing statement. I will be responsible for any accrued interest, attorney fees, and/or collection costs that may be imposed to collect any amount due on my account. To the extent permitted under applicable law, I authorize release of information relating to my account.
We are excited about the opportunity to serve you and provide endodontic care at the highest level of technical and human excellence.

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Patient/Responsible Party Signature **Date**