

**Robert Garland DDS, Inc.  
Benjamin P. Johnson DDS  
321 N. Breiel Blvd.  
Middletown, Ohio 45042  
(513) 424-3971**

**Patient Payment Options**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
 Doctor Name \_\_\_\_\_

**Pre-Payment for Entire Treatment Plan:**

- Total Treatment Plan: \$500 - \$2000 = 5% discount for cash or check payment. (3% discount for credit card payment)
- Total Treatment Plan: \$2000 and over = 10% discount for cash or check payment. (8% discount for credit card payment)
- 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 \_\_\_\_\_

**Payment Over Several Months**

- 0% Financing for 3 Months, 6 Months or 12 Months                      Monthly Payment \_\_\_\_\_
- Subject to third party approval    for \_\_\_\_\_ months

**Extended Payment Option**

- A Third Party Company Also Offers 24 through 60 Month Payment Plans
- Patient Pays All Interest

<i>Total Itemized Fee</i>	\$ _____
<i>Estimated Insurance Portion</i>	\$ _____
<i>Total</i>	\$ _____
<i>Deductible</i>	\$ _____
<i>Estimated Patient Portion</i>	\$ _____

EXPLANATION: Insurance portion is an estimate. Amount of 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 agree to pay reasonable attorney's fees, court costs, and collection costs incurred by the Dentist in collection and enforcement of the debt.*

Accepted: \_\_\_\_\_ Date: \_\_\_\_\_

Financial Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_