East Dental Family Dentistry, PLLC
1346 Payne Avenue
St. Paul, MN 55130
651-774-6085 - office@eastdental.org - eastdentalmn.com

PATIENT PAYMENT AGREEMENT

Thank you for the opportunity to help you meet your oral health goals. Please fill out the following financial arrangement, **sign, date, and send back** to us:

The current cost of treatment I have rendered upon with East Dental Family Dentistry. is approximately $_____(up to *8% finance charge applies with aging balances beginning with the 4th payment cycle*). Note: Credit/HSA/Debit cards incur a 3% bank fee. This is a revolving credit agreement.

I have discussed payment options and agreed upon a payment plan with East Dental Family Dentistry. In the case that my insurance does not reimburse the full amount from services rendered, I understand that I am responsible for paying any co-payment, deductible, and, or any uncovered services my insurance policy does not benefit. I have agreed to pay my patient portion of the treatment fee in the following way:

AUTOPAY- Option 1: ___I agree to pay $ _____ today and $_____per month on the _____ day of the month, thereafter, until the above account(s) is paid in full. This amount will be automatically deducted for your convenience unless you contact us to change the amount or date.

Credit/HSA/Debit number: _____EXP Date_____
CVS: _____ Billing address (OFFICE USE ONLY): _____Zip Code: _____

Option 2: ___I agree to pay $ _____ today and $_____per month thereafter, until the above account(s) is paid in full. I choose to pay by check, credit card, Venmo or cash each month.

Option 3: ___I agree to pay in full by Check, Cash, Venmo or Credit Card when statement is received.

We are here to help you get your dental needs met. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, **we request that you contact us promptly for assistance in the management of your account**.

Name(s) of patient(s) covered by this agreement: entire account will be included, unless otherwise stated.

Patient Name: _____ Pt Acct Number: _____

Responsible Party Signature:

X_____

Staff Initials: _____ Date: _____