PATIENT TREATMENT PLAN

Date: December 12, 2017

Patient Name: Christine Harper

The following is an outline of your dental treatment plan. You will be informed if any changes during treatment become necessary. The financial summary and insurance and patient Co-Pay amounts are an estimate only.

Description	Th#	Fee	Write-off	Allowed	Insurance	Balance	Expl
Deep Sedation/Gen Anesth, Each 15 Min		254.00	-162.00	92.00	82.80	9.20	90 %
Deep Sedation/Gen Anesth, Each 15 Min		254.00	-162.00	92.00	82.80	9.20	90 %
Therapeutic Drug Injection - 2 Or More		104.00	0.00	104.00	0.00	104.00	0 %
Removal - Partially Bony Impacted	1	516.00	-277.00	239.00	215.10	23.90	90 %
Removal - Partially Bony Impacted	16	516.00	-277.00	239.00	215.10	23.90	90 %
Removal - Completely Bony Impacted	17	605.00	-311.00	294.00	264.60	29.40	90 %
Removal - Completely Bony Impacted	32	605.00	-311.00	294.00	264.60	29.40	90 %
Total		**2,854.00**	**-1,500.00**	**1,354.00**	**1,125.00**	**229.00**	

† $10,000.00 annual maximum applied

Total Treatment Fee for above procedures:	**$1,354.00**
Your insurance company may pay:	$1,125.00
In which case you would pay:	**$229.00**
Maximum allowable benefits for current year =	$10,000.00
Payments already paid to date =	$0.00
Remaining balance for this year =	$10,000.00

We have 2 options for payment, please select below:

OPTION 1: I will pay the full Total Treatment Fee as outlined above. Any insurance payment will be assigned to me, the patient. _____

OPTION 2: I will pay my Estimated Copay on the day of procedure however, I understand that I am fully responsible for the Total Fee should my insurance company not fulfill their agreement as outlined above. I agree this is MY benefit plan and regardless of benefits quoted, I am responsible for the Total Fee. _____

The risks, benefits and alternatives, including the consequence of declining treatment have been explained to my satisfaction by the doctor. If I decline care, I understand I assume full responsibility.

Regardless of the above estimated insurance coverage, I understand that all fees incurred are my responsibility and I will provide payment to the office within 30 days of receiving a statement.

Signed_____ Date_____

Treatment Plan presented by _____BCB_____ Date_____