

**Financial Agreement**  
*William A. Stanley D.D.S.*

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Tel. \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

*All dental treatment and services in this office are listed individually by procedure, have standard fees, and are coded for dental insurance claims. The fees are identical for patients with or without dental insurance. We accept any form of dental insurance that will pay private providers, but **do not participate in HMO and PPO plus Plans** because they often restrict treatment or require "alternate treatment" that may not be the best suited for the patient's condition. I have read this and understand this.*

\_\_\_\_\_ (Initial)

**I DO NOT HAVE DENTAL INSURANCE:**

- ( ) I elect to pay with cash, check, or by Credit Card ( MasterCard or Visa ) and my balance will be paid on each treatment visit.
- ( ) On extensive treatment, I elect to pay 50% on the preparation date and will pay the balance at the completion appointment.
- ( ) On extensive treatment I will pay 50% on the preparation date and will authorize Dr. William A. Stanley's office to divide the balance into three equal monthly payments. I will supply the credit card information necessary for automatic charges on the agreed upon day each month.

**I HAVE DENTAL INSURANCE:** Company Name: \_\_\_\_\_

Policy # \_\_\_\_\_ Group or I.D. # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relation \_\_\_\_\_

- ( ) I will pay my deductible and all co-payments by cash, check, or credit card on each treatment visit.
- ( ) On extensive treatment I will pay 50% of the estimated patient portion on the preparation date and the balance at the completion date.
- ( ) On extensive treatment I will pay 50% of the estimated patient portion on the preparation date and the balance in three equal monthly payments.

*I understand that I will be responsible for any balance not paid by my Dental Insurance.*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

