This Payment Agreement ("Agreement") is entered into on this ___ day of _____**, 20**, by and between:

Dental Provider:
Name: _____
Practice Name: _____
Address: _____
Phone: _____
Email: _____

Patient/Responsible Party:
Name: _____
Address: _____
Phone: _____
Email: _____

Payment Terms

The total cost of the dental services is estimated to be: **$_____**

The Patient agrees to the following payment method:

☐ **Payment in Full at Time of Service**
☐ **Installment Plan** – As outlined below:

- Initial Payment (Due at First Appointment): **$_____**
- Remaining Balance: **$_____**
- Number of Installments: ____
- Installment Amount: **$_____**
- Payment Frequency (e.g., weekly, bi-weekly, monthly): _____
- Final Payment Due By: _____

Payments are to be made via:
☐ Cash ☐ Check ☐ Credit/Debit Card ☐ Other: _____

Late Payments and Default

- **A late fee of $____ may be charged for any payment not received within ___ days of the due date.**
- **If the Patient defaults on payment, the Dental Provider reserves the right to suspend treatment until payment is brought current.**
- **Unpaid balances over ___ days may be sent to collections, and the Patient will be responsible for any additional collection costs or legal fees.**

Insurance

If applicable, the Patient authorizes the Dental Provider to bill their insurance company directly. The Patient understands:

- **They are responsible for any co-pays, deductibles, or charges not covered by insurance.**
- **Insurance estimates are not guarantees of payment.**
- **The Patient is ultimately responsible for the total amount owed for services provided.**

Agreement Acknowledgment

By signing below, both parties agree to the terms outlined in this Payment Agreement. The Patient acknowledges they have received a copy of the treatment plan and cost estimate, and that they understand and accept their financial responsibilities.