Chiricahua Community Health Centers, Inc.
"Caring for patients, building healthy communities"

Dental Self-pay Financial Notice

(520) 459-3012

Patient Name: _____ Medical Record Number: _____

Date of Service: _____

Select one payment option:

☐ **I agree to pay the prompt payment incentive fee of 75% of the estimated charges at the time of service. Payment of 75% of the provided estimate prior to the receipt of services rendered will be considered paid in full**. There will be a fee for any additional procedure NOT included in the original treatment plan.

OR

☐ **I decline to pay the prompt payment incentive fee of 75% of the estimated charges.** I agree to pay 50% of the estimate which is due at the time of service. A payment plan with a term of not more than 6 months (and a minimum of $25 if less than $150) must be setup for the remainder of the 50% balance. There will be a fee for any additional procedure NOT included in the original treatment plan.

DISCLAIMER: I also understand prescriptions, non-CCHCI radiology and laboratory orders, and specimens sent to a lab for processing are additional charges and will be owed to the rendering facility.

By signing below, I agree to pay for all fees incurred during my visit today.

Patient / Guarantor Name:	**Relationship to Patient:**
Mailing Address:	**Phone Number:**
Signature:	**Date:**