Mark A. Miely, DDS

Family & Cosmetic Dentistry

Creating Beautiful Smiles

PAYMENT OPTIONS

614-451-2100 - www.MarkAMielyDDS.com

Patient Name:_____Date: _____ _____

Summary of Treatment Plan _____

Total Fee: $_____ Presented by: _____

Down Payment: $_____ Estimated Insurance Portion: $_____Total Due: $_____

Credit Card Number_____ Exp. Date_____ Charge Date: ❑ 1st ❑ 15th

Save Money

Payment in Full - For Amounts Due over $1000

Due at the time of scheduling or 2 working days prior to appointment.

5% Discount - You Save: $_____ Total Fee: $_____

90 Days Same As Cash

Initial payment due at time of scheduling. Down Payment: $_____

❑ CC on File 2 equal payments: $_____

1/2 & 1/2

1/2 Amount Down: $_____ Second Payment Due _____ $_____

We can keep a credit card on file for agreed upon amount or accept post-dated checks.

No Interest Financing

Care Credit - *Online Approval Process*

(for $300 or more) 6 Months Deferred Interest Avg. Monthly Payment of $ _____

(for $300 or more) 12 Months Deferred Interest Avg. Monthly Payment of $ _____

Extended Payments

Care Credit - *With Interest Financing*

Interest calculated at 14.99%; actual interest may vary.

$1,000-$24,999	24 months	$_____
$1,000-$24,999	36 months	$_____
$1,000-$24,999	48 months	$_____
$1,000-$24,999	60 months	$_____

The plan for me is:

- ❑ Save Money, Prepayment Courtesy
- ❑ 90 Days Same As Cash
- ❑ 1/2 & 1/2
- ❑ No Interest Financing
- ❑ Extended Payments

Notes:

This quote is valid for 90 days. I, the patient/guardian, agree to be a hereby am fully responsible for total payment for procedures in this office. I understand that insurance coverage noted here is only an estimate. I understand that payment for dental service is due regardless of the benefits paid by my insurance company, and that if denied in part or whole, payment in full becomes my responsibility. Any outstanding balance over 90 days will be turned over to a collection agency. At this time, I understand I will be responsible for the collection fee in this recovery of this debt. I have read the above and hereby agree to the contract dated today.

Patient (or responsible party) Signature: _____

Print Name:_____**Date:** _____

Reset Save Print