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Temporomandibular Joint Disorders
Fellow: American Academy of Craniofacial Pain
International College of Cranio-Mandibular Orthopedics

Statement of Patient Understanding

I understand that the treatment plan provided to me is an estimate of what total cost of treatment will be and is used for planning purposes. I understand that I am responsible for the total cost of my treatment, which may be higher or lower than the amount on the initial treatment plan.

I understand that insurance may not cover all or part of my treatment. If insurance does not cover all of or part of my treatment, I am responsible for the balance of the cost that is not covered by insurance.

I understand that by agreeing to a payment plan, that I will make timely payments in the amount agreed and the day agreed with the office of Dr. Parker and Dr. Mistry. If I do not make the payments as arranged, my debt can be sent to collections.

I agree to pay the amount owed to Dr. Parker and Dr. Mistry for the services performed.

I understand the information detailed above and agree to treatment by Dr. Parker and Dr. Mistry.

Signature of Patient, Parent and /or Guardian

Date

Print Name

Payment Plan

1/3rd down payment of \$ _____ on _____ with a remaining balance of \$ _____

Estimated cost of treatment: _____

Remaining balance: _____

Number of months for payment plan: _____

Amount to be paid: _____

Day of the month for payment: _____ Payments must be made **by the end** of each month.

Your first payment starts in _____

Signature of Patient, Parent and /or Guardian

Date

Print Name

Payment Options include cash, check, Visa, MasterCard, Discover and American Express cards, and CareCredit.com (Subject to approval). Statements with details of services performed and amounts will be sent out at the end of each month.