PAYMENT OPTIONS
FOR THE PATIENTS OF
MICHAEL L. DAVIDSON, D.D.S.

Our office strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. At the onset of your treatment, we will provide you with an estimate of your total treatment costs. Our goal is to help you afford your dental choices.

Please understand that this will only be an estimate. Should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Be assured that we will notify you of fee changes and obtain you approval prior to proceeding with treatment. Please take a moment to review the financial options offered and indicate your choice payment.

PLAN A

Payment in full on the day of each visit. We are happy to accept cash, check, or credit card at the time of service.

PLAN B

You may use your credit or debit card to make payment. We gladly accept MASTER CARD, VISA or DISCOVER CARD..

PLAN C

We are pleased to offer our patients another extended monthly payment plan option through a dental financing company extended monthly payment plan option through a dental financing company called CARECREDIT.
Again, feel free to contact any member of our staff if you have questions regarding the payment options described above. We thank you for trusting us with your dental care needs and hope that you will let us know if we can improve our service to you in any way.

I, ____, have chosen option __________(above) accept full financial responsibility for this account and all dentistry performed upon my dependents in this dental office. I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I also understand that any insurance claim not paid in full after 60 days will become my responsibility to pay at the time.

PATIENT SIGNATURE______________________________________

STAFF SIGNATURE______________________________________

DATE______________________________________