Carolina Family Health Centers, Inc.

Carolina Family Dental Center • Freedom Hill Community Health Center • Harvest Family Health Center • Wilson Community Health Center

Dental Treatment Payment Plan Worksheet

Patient Name: _____
Last *First* *Middle*

Date of Birth: _____/_____/_____ Medical Record Number: _____
MO DAY YR

Front Office Associate: _____ Patient's Provider: _____

☐Tier 1=0% ☐Tier 2=25% ☐ Tier 3=50% ☐Tier 4=75% ☐Tier 5=100%

Procedure Code	Procedure Level	Price	Lab if Applicable
Totals			

Total Price _____
Less: Total Labs _____
Less: Nominal/Minimum Fee _____
Amount Available for Discount _____
SFS Tier % _____
SFS Amount _____

Total Payment
Lab total from above _____
Nominal /Minimum Fee from above _____
SFS Amount from above _____

Patient Responsibility _____
Patient Discount _____

PATIENT MUST PAY THE LAB FEE IN FULL ON THE FIRST VISIT

Payment #1 _____
Payment #2 _____
Payment #3 _____
Total _____

This payment plan is effective for 120 days or if income level changes to a different tier before treatment has begun. Payment plan reflects the estimated balance due from patient after any insurance payments. Any changes not covered by insurance will become the responsibility of the patient.

_____
Patient/Parent/Legal Guardian's Name (printed)

_____ _____
Patient/Parent/Legal Guardian's Signature *Date*
(Parent must sign for minor child)

_____ _____
Staff's Signature *Date*