

DR JANE E BOROKY B.D.S.(Adel), Dip. Clin. Hyp.

ST PETERS DENTAL CLINIC

51 Stephen Terrace
St Peters SA 5069

Tel: (08) 8362 7650 Fax: (08) 8363 7435

Email: info@stpetersdentalclinic.com.au

Patient Payment Arrangement

Thank you for the opportunity to help you meet your oral health goals. During our discussion of your treatment recommendation, the following financial arrangements were made:

The cost for your treatment is \$_____. Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. We will inform you if this occurs and you will be given the option of continuing or changing treatment.

You have agreed to pay your patient portion of the treatment fee in the following way:

Payment Amount: \$_____ weekly / fortnightly / monthly

Deposit: \$_____ Remaining: \$_____

First payment date: _____

Last payment date: _____

If you have questions about your treatment plan or the choice of payment options, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

We look forward to seeing you at your scheduled appointment on _____ at _____.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)