Patient Treatment/Financial Agreement
Insurance & Non-Insurance

Patient Name _____ Date _____
Responsible Party (if different) _____

Periodontal Disease Therapy
Program 3 & 4

Services Description	Code	Est. Fees
• Periodontal Scale UL	04341	$230.00
• Periodontal Scale LL	04341	$230.00
• Periodontal Scale UR	04341	$230.00
• Periodontal Scale LR	04341	$230.00
• Irrigation	09630	$55.00

One Month Follow-Up

Services Description	Code	Est. Fees
• Prophylaxis	01110	$80.00
• Fluoride Desensitizer	09910	$50.00

Total Fees: $1105.00

Oral hygiene instructions, re-evaluation, and periodontal charting are no charge.

The calculator is an estimate. Estimate is based on diagnostic information available at this time and is subject to change if there is a necessary change in treatment. The fees are guaranteed for six months. The purpose of this procedure has been explained to me. I understand if I have any further questions I can call and speak to my hygienist.

Patient signature _____ Date _____

I understand that my insurance requires a pre-estimate before having this procedure. However I would like to make an appointment prior to receiving my pre-estimate from my insurance. I realize it takes 3-4 weeks to receive the pre-estimate from my insurance. I understand there is no guarantee with out the pre-estimate that this procedure will be covered. I understand if my insurance does not pay for this procedure I am responsible to pay the full amount.

Hygienist signature _____ Date _____