RIVER HILLS DENTISTRY

GENERAL • COSMETIC • IMPLANTS • PERIODONTICS

4337 Lynx Paw Trail ♦ Valrico ♦ Florida ♦ 33569 ♦ (813) 654-4223

Estimate of Dental Benefit Coverage

Patient Name:_____ **Date:**_____

We are concerned about your dental health. We look forward to helping you with your dental care. **Please remember that your dental insurance is your responsibility...** but we can help. Regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you, the patient, are responsible for the total treatment fee. The outlined estimate is based on limited information obtained from your insurance company. We will submit it to your insurance company.

Recommended Treatment	Fee

Total Treatment Fee_____
Estimated Insurance Payment (Up to your yearly Maximum)_____
Estimated Patient Payment_____

I understand and accept the treatment plan above. I agree to the FINANCIAL RESPONSIBILITY for the total fee. Then fees on this treatment outline will be honored for 30 days. After that time, the fees are subject to adjustments.

I understand the above is only an estimate:_____ Date:_____
Remarks_____
_____
_____