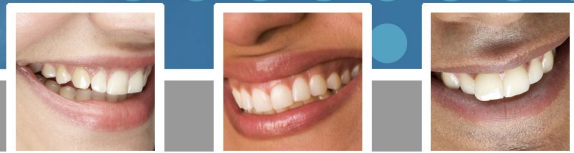


Ballenger Creek Dental Associates

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FINANCIAL MENU

A) Prepay Courtesy

A prepayment courtesy of 5% (10% Senior Citizen, over 65) will be subtracted from the total patient obligation (not from any portion due from insurance company) if the patient obligation is paid in full at the first treatment visit. This option is available only if the total patient obligation is greater than \$1,000.

B) Care Credit - Up to 12 Months Zero Interest Financing

With approval from Care Credit (a separate line of credit for health care services only), Dr. LeMonnier will pay the interest for up to 12 months. The application is very brief, and their response time is almost immediate. Note: Although they allow balances to carry beyond the specified time period, we urge you to pay it off during this time - on the first day of the month beyond the specified time period, you will be responsible for the interest, retroactive to the very first day of the loan. (Prepay Courtesy not eligible with Care Credit).

C) Three payments Zero Interest

Total patient obligation may be divided as follows: Three equal checks (or pre-signed credit card slips), post-dated for three consecutive months. Note: Balance payments will be written at the initiation of treatment, post-dated for 30 and 60 days. This option is available only if the total fee is greater than \$500.

D) Pay as You Go

You may choose to pay your obligation for each visit, at the completion of each visit.

FORMS of PAYMENT and BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following (including any combination thereof): Visa, MasterCard, American Express, Discover, Cash, Money Order, Personal Checks, or one of the financing options listed above. Balances >60 days will incur a finance charge of 18%APR, a fee will be incurred for returned checks, and the cost of third party collection may be added to your balance.

INSURANCE

It is our pleasure to assist you by completing your claim forms. If your carrier is up to date your claim will be transmitted electronically before the end of the treatment day! As a courtesy, in addition to filing the claim, we will initially ask you only for your estimated co-payment. Please understand that this is only an estimate, and is based upon the information you provide, as well as that available to us from your insurance carrier (to which we do not always have access).

The range of benefits depends solely on what your employer wishes to purchase. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, your actual percentage reimbursement may be lower than the level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office. Once your carrier has paid the claim, any difference will be due upon receipt of our statement. The financial obligation for dental treatment is between you and our office. The insurance company is responsible to you, and not to our office. We will happily assist you in obtaining your benefits in any way that we can, however, we can not be responsible for denial of coverage by your insurance company.

By signing this I acknowledge that I understand my financial responsibility. Furthermore, I acknowledge that I am responsible for payment for all services rendered on my behalf or my dependents.

Signature: _____

Date:

Response Date: