Corrective Care - Third Party

Costs associated with this Care Plan

_____ visits x _____ per visit (avg.) = _____

_____ x-ray(s) x _____ each = _____

Total = _____

(If applicable) Total Estimated Insurance Payment = _____

Remaining Balance = _____

Reduced Payment Total = _____ Savings: _____

(If applicable) Patient Responsibility Co-Pays = _____ Total: _____

Monthly Enrollment
(10% Discount)

Savings: = _____

Deposit: = _____

Balance Due: = _____

_____(Mos.) = _____

Pre-Payment Discount
(20% Discount)

Savings: = _____

Balance Due: = _____