Patient Name: ______________________________________ Date: ___________

Average Invisalign Cost: **$5500-$7000**

Dentistry at Suburban Square

Unbelievable All Inclusive Invisalign Treatment Only **$3995**

Initial consult, X Rays, photos, & scan, Invisalign Clear Aligners,
any necessary additional aligners, a single set of retainers, all Invisalign treatment visits

Special Invisalign Coupon 2 weeks ONLY **Expires** ______________ **- $600**

WOW! Bringing Your Cost down to an amazingly low **$3395**

Your Estimated Insurance Reimbursement sent directly to you over the course of treatment: $______________

Upon completion of your Invisalign consultation our front desk will schedule you for a Data Collection appointment
(Scan, photos, X-rays – all included). We will collect a $250 fully refundable deposit to lock in the limited time lowest discount. That deposit will be credited towards full payment due for the Data Collection appointment. Below are our Easy Funding Options:

OPTION 1 LOWEST TOTAL COST **in full at first appointment:**

$3395 check, cash, credit card, or HSA (at scanning/data collection appointment)

Any insurance reimbursement will be sent directly to you.

OPTION 2 NO CREDIT CHECK **with approval thru Varidi Financing:**

$79 a paycheck $0 down 9% interest for 24 months totaling $3995

May be combined into one paycheck a month. Not used with HSA/FSA card, but can be submitted for reimbursement.

OPTION 3 LOWEST MONTHLY PAYMENTS **with approval thru Care Credit:**

$167 monthly $0 down 0% interest for 24 months totaling $4008

$299 monthly $0 down 0% interest for 12 months totaling $3588

OPTION 4 LOW DOWN PAYMENTS with in-office payment plans:

$1000 down $249.59 bi-weekly for 6 months totaling $3995

$1500 down $349.17 bi-weekly for 3 months totaling $3595

OPTION 5 INSURANCE PAYMENT sent to us instead of you:

$3579 minus $______________ = down payment of $________________

(Your estimated insurance) (No less than $1000)

Delta and United Concordia can be used, but will pay you directly, making this option unavailable.

Do It BETTER, QUICKER, for LESS COST

We won't stop until you are happy with your smile.

Patient Signature: ______________________________ Date: ______________ Team Member Initials:_______

With OPTION 5 Estimating Insurance Coverage Agreement

I understand that if my insurance policy terminates, maximum runs out or is already used up, or does not cover the full estimate amount, I will be responsible for resolving the remaining balance immediately.

Patient or Responsible Party Signature: ____ Date:_____________