

Sample Federal Truth-In-Lending Form

John Bicuspid, D.D.S.
1234 Main Street
Your Town, USA 10001
800-555-1212

Patient Name: Lisa Taylor

Responsible Party Name: Same

Estimate of total treatment charges	\$	<u>2400</u>
Less anticipated insurance payment	\$	<u>800</u>
Anticipated patient payment	\$	<u>1600</u>
Less initial investment	\$	<u>400</u>
Actual amount financed	\$	<u>1200</u>
Finance charge	\$	<u>4.06</u>
Finance charge expressed as Annual % Rate (APR)		<u>18 %</u>
TOTAL PAYMENT DUE	\$	<u>1204.06</u>

To be paid in one payment of \$ _____

On (date): _____

To be paid in 3 weekly/monthly payments of \$ 400 each,
due on Oct 20, Nov 20 and Dec 20 (\$404.06 due in Dec includes interest) .

As a courtesy to you we do accept assignment of benefit payments from most insurance companies. This is an **estimate** based on limited information obtained from your insurance company. The amount of your insurance company's payment is determined by the level of coverage purchased for you by your employer. Please remember that your dental insurance is your responsibility. As a courtesy, we will help you with claims submission, however, we cannot guarantee what will be paid by your insurance company. We allow 30 days for your insurance company to make payment. After 30 days all inquiries and follow up become your responsibility. No finance charges will be applied if all balances are paid in full within 60 days of the date of service.

Responsible Party Signature : Lisa Taylor Date: 09/21/20XX

Financial Coordinator Signature : Susan Serrano Date: 09/21/20XX