

# TREATMENT PLAN

Friday, July 18, 2014 at 12:22 pm

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Spokane OMS / Post Falls Location

602 N. Calgary Ct. Suite 202

Post Falls, ID 83854

(509) 926-7106

	<i>Patient Information</i>	Account Balance:	\$84.00	Estimated Balance
	Main Phone:	Patient:	\$21.00	
	Alt. Phone: ( ) -	Insurance:	\$63.00	
Guarantor:		Next Recall:	Next Appt: Friday, 08/29/2014 @ 9:00am	

Code	Description	Tth	CPT	Dx	Fee	Adjustment	Insr. Total (Est)	Patient Total
00138	Ltd Oral Exam / Teeth		99201		\$84.00	\$21.00	\$63.00	\$0.00
Narrative:								
09210	Local Anesthesia				\$0.00	\$0.00	\$0.00	\$0.00
Narrative:								
09612	Multi inject Intra Anti/Ther Inj.		96375		\$117.00	\$0.00	\$0.00	\$117.00
Narrative:								
09220	General Anesthesia		00170		\$464.00	\$87.00	\$163.50	\$213.50
Narrative:								
07240	Complete bony-impacted	1	41899		\$525.00	\$66.00	\$229.50	\$229.50
Narrative:								
07240	Complete bony-impacted	16	41899		\$525.00	\$66.00	\$229.50	\$229.50
Narrative:								
07230	Partial Bony Impacted	17	41899		\$471.00	\$45.00	\$213.00	\$213.00
Narrative:								
07230	Partial Bony Impacted	32	41899		\$471.00	\$45.00	\$213.00	\$213.00
Narrative:								
Procedures for this Appt / Phase = 8					\$2,657.00	\$330.00	\$1,111.50	\$1,215.50
TOTAL					\$2,657.00	\$330.00	\$1,111.50	\$1,215.50

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## Notes

The estimated patient portion that will be due in FULL at the time of service will be \$1215.50

Thank you,

Terry H.  
Financial Coordinator

## Financial Policy

Patients are requested to pay their estimated portion of the charges at the time of treatment. This treatment plan is an ESTIMATE ONLY based on the information you provided to us regarding your insurance benefits. Please be aware that some insurance companies will pay a claim percentage based on their "usual and customary" fees, not our actual charges and that pending claims may alter this estimate. As a courtesy, we will bill your insurance for you; however the responsibility for payment remains with the patient. Any balances unpaid by the insurance company will be the patient's responsibility. For individuals with insurance, your signature below authorizes your insurance benefits to be paid directly to SOMS. If you are having a biopsy or blood draw in our office there will be a separate charge from the lab that can be billed to your medical insurance company. We accept credit cards, Check, Cash, Care Credit.

\_\_\_\_\_  
Signature of Patient or  
Guarantor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Signature for Practice

\_\_\_\_\_  
Date