



10217 19th Ave SE Suite 203
Everett, WA 9820
425.385.8130

Invisalign Treatment Plan

Patient Name: _____ Date: _____

Average Invisalign Cost: \$5,500-\$7,500

19th Avenue Dental- All Inclusive Invisalign Cost: Our Sale Price \$3,879

Includes: initial consultation, photos, digital scan, Invisalign clear aligners, a single set of retainers at end of treatment, & all Invisalign treatment visits

New Patient Invisalign Coupon (2 Weeks ONLY*) - \$600 off!
(Expires: _____)

All Inclusive Invisalign Patient Portion \$3,279

- **Option 1 : Lowest Total Cost (Pay in Full)**
\$3,279 – Pay in full with: Cash Check, Credit Card (3.5% fee), Debit Card, or HAS/FSA
- **Option 2: Financing with HFD-Everyone is Approved! \$89 per paycheck**
Only \$4300 if paid off within a year, otherwise 29.99% interest for 36 months totaling \$6445
There is a soft credit check that is not reported. 100% Approval expect prior money laundering, bankruptcy or HFD delinquency
- **Option 3: Financing with SunBit: \$500 down payment/ \$231.12 per mo. 12 months**
(down payment and monthly payment amounts may vary due to credit score)
- **Option 4: In- Office Financing**
\$1,000 down \$334.75 bi-weekly payments for a total of 4 months and 0% interest totaling \$3,678
- **Option 5: Insurance Payment sent to us**
\$3,579 minus \$ _____ = Down Payment of \$ _____
(Estimated Insurance) (No Less than \$1,000)

Do It BETTER, QUICKER, for LESS COSTS with 19th Avenue Dental!

Patient Signature: _____ Date: _____ Team Member Initials: _____

Once payments terms are secured there are no refunds



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Invisalign Treatment Plan Terms and Conditions

Option 2:- Financing with HFD (everyone is approved \$89 per paycheck)

There is a soft credit check that is not reported on your credit score. I understand and agree that all charges for Invisalign Data Collection and payments that I have made and payments and payments that I have agree to make are non-refundable and non-reversible for any and all reasons. I understand and agree that any attempt to reverse these charges, not fully pay these charges, dispute these charges, through financial and or legal will incur additional costs. And I understand and agree that I will be fully responsible for any and all these additional costs incurred by 19th Avenue Dental.

Patient Signature: _____ **Date:** _____

Option 4: In office Financing:

- ✓ A credit or debit card is required to have on file (this card will be ran automatically bi-weekly)
- ✓ 3.5% credit card processing fee will be applied to each credit card payment (debit cards, cash, HAS/FSA and checks have no additional fees)
- ✓ Late payments may be subject to a fee of \$50 per mo.
- ✓ In the event the card on file becomes inactive, declined, or otherwise unusable, the patient agrees to promptly provide an updated card to put on file to avoid late fees and possible collections
- ✓ Treatment will be paused if the account becomes delinquent

Patient Signature: _____ **Date:** _____

Option 5: Estimating insurance coverage:

I agree that I am financially responsible for the total cost of treatment regardless of my insurance coverage. I understand that any insurance estimate provided is not a guarantee of payment. I understand that after treatment is completed the office will continue to seek payment from my insurance company for the remaining balance. If the insurance does not pay the remaining balance within 12 months, then I understand that I will be fully responsible for any balance remaining.

Patient Signature: _____ **Date:** _____