



BLACKHART
DENTISTRY

1419 W F St.
Oakdale, CA 95361
209-847-0309

Patient Name: _____ Date: _____

Invisalign Treatment Costs

Average Invisalign Cost: \$5500-\$7500

Our Standard Fee: \$6942

Our sale cost*: \$3942

New Patient Invisalign Coupon **2 weeks ONLY***

-\$600

* Sale fee and coupon cannot be combined with any other discount or coupon

All Inclusive Invisalign Treatment

\$3342

Includes: Initial consult, x-rays needed for Invisalign, photos, scan, Invisalign Clear Aligners, any necessary additional aligners, a single set of clear retainers, all Invisalign treatment visits.

Your estimated Insurance Reimbursement sent directly to you over the course of treatment: \$ _____
[Estimated Insurance Reimbursement]

Option	Payment Details	Total Cost	Notes
☐ LOWEST TOTAL COST	Pay in full at data collection appointment check, cash, credit card, HSA/FSA	\$3342	Any insurance reimbursement will be reimbursed to you.
☐ LOWEST MONTHLY PAYMENTS	\$172/mo, \$0 down, 0% interest for 24 months with approval thru Care Credit or Cherry Financing	\$4128	Also available: 6, 12, or 18 month financing with Care Credit or Cherry for different discounted costs.
☐ HIGH APPROVAL RATE	\$89 bi-weekly with \$89 at signup with approval thru HFD Financing (payment is linked directly to your bank account).	\$4300 -\$6445	Only \$4300 if paid off within a year, otherwise 29.99% interest for 36 months. *soft credit check only with a 99.9% approval.
☐ LOW DOWN PAYMENT	\$1000 down, \$342.75 bi-weekly for 4 months with in-office payment plans.	\$3942	
☐ INSURANCE PAYMENT	\$3642 minus _____ [Your Estimated Insurance] = down payment of _____ (no less than \$1000)	Varies	Delta and Blue Cross will pay you directly, making Option 5 unavailable.

Patient Signature: _____ Date: _____ Team member initials _____

Once payment terms are secured there are no refunds

Agreement for Option 3: HIGH APPROVAL RATE with HFD Financing

I understand and agree that I have been charged for Invisalign Data Collection (which occurs the day I pay or agree to payment terms) which has been requested and received as of the date I am signing this document. I understand and agree that all charges for Invisalign Data Collection and payments that I have made and payments that I have agreed 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 and/or any other means may and will incur additional costs. And I understand and agree that I will be fully responsible for any and all of those additional costs incurred by Blackhart Dentistry.

Patient or Responsible Party Signature: _____ Date: _____

Agreement for Option 5: Estimating Insurance Coverage

I understand that if my insurance policy terminates, the 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: _____

Option 2: Available Financing with Care Credit and Cherry Financing

\$0 down and 0% interest promotional financing options for orthodontics

Term in months	Total Amount	Monthly Payment
24	\$4128	172
18	\$4068	\$226
12	\$3984	\$332
6	\$3810	\$635