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FINANCIAL AGREEMENT

Full-Arch & Full-Mouth Implant Surgery | Dr. Elvis Filo

Patient Information

Patient's Full Name: _____

Date: _____

Phone: _____

Email: _____

Procedure

Type of Procedure: _____

Treating Dentist: _____

Surgery Date: _____ Jaw(s): Upper Lower Both

Treatment Fees

Total Fee: \$ _____ Required Deposit: \$ _____

Deposit Received: \$ _____ Balance Due: \$ _____

Payment	Amount	Due
Deposit (required to confirm surgery date)	\$	At time of booking
Interim Payment (if applicable)	\$	
Final Balance	\$	At delivery of final prosthesis
TOTAL	\$	

Full-arch and full-mouth reconstruction surgery dates will not be confirmed or held until the required deposit has been received. Accepted payment methods: Cash • Debit • Visa • Mastercard • Certified Cheque • Financing.

Insurance

Provider: _____ Policy / Group #: _____

Est. Benefit: \$ _____ Patient Portion: \$ _____

Note: The patient is responsible for the full treatment fee regardless of insurance reimbursement.

Cancellation & Deposit Policy

Cancellation notice: A minimum of 5 business days' notice is required to cancel or reschedule a surgical appointment.

Deposit refund policy: Deposits are non-refundable if a surgical appointment is cancelled with less than 5 business days' notice, or if the patient elects not to proceed with treatment after the surgery date has been booked and materials ordered. In cases where surgery must be cancelled due to a medical emergency or circumstances beyond the patient's control, deposit refund or transfer will be considered at the discretion of the clinic.

Full-arch and full-mouth reconstruction surgeries require significant preparation time, including laboratory work, material ordering, and surgical planning. Once a surgery date is confirmed and a deposit received, these resources are committed on your behalf.

Patient Agreement

By signing below, I confirm that I have reviewed and understood the treatment fees, payment schedule, deposit requirement, insurance terms, and cancellation policy outlined in this agreement. I agree to make payments in accordance with the terms above, and I understand that my surgery date will not be confirmed until the required deposit is received.

Patient Signature

Date

Clinic Representative

Date