SmilePartners
Healthy smiles, healthy lives

Patient Co-pay Work Sheet

Name:_____

Eligibility for reduced fees is based on income. Proof of income required at first visit (Social Security statement, tax return or other official documents).

Yearly income:_____ Verified by:_____

Co-pay fee scale based on annual income (Please circle one):

$10,890 - $21,780 = **$45** $21,780 - $36,775 = **$75** $36,775 or more = **$95**

I understand that I am responsible for any and all charges for services provided to me by Smile Partners. I understand that I may be eligible for reduced fees based on my proof of income.

Signature:_____ Date:_____

If you have private dental insurance, please complete the following:

Name of insured:_____ Birth date:_____

Group number:_____ Subscriber ID:_____

Insurance company:_____ Insurance co. phone #:_____

Insurance company address:_____

I authorize any payments for services provided to me to be paid directly to Washington State Smile Partners.

I understand that I am responsible for any and all charges for services provided to me, regardless of insurance coverage.

Signature:_____ Date:_____

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