HOPE DENTAL
LYNNWOOD

4713 168th St. SW #102
Lynnwood, WA 98037
(425) 954-8899

INVISALIGN INVESTMENT GUIDE

Patient name _____ Date _____

A clearer path to your new smile

One straightforward fee, flexible ways to pay, and a treatment plan tailored to you.

HOPE DENTAL ALL-INCLUSIVE INVISALIGN

Regular fee
$4,189

LIMITED-TIME COUPON
-$600

YOUR ALL-INCLUSIVE FEE

$3,589

What your fee includes

Initial consultation, necessary X-rays, digital photographs and scan, Invisalign clear aligners, clinically necessary additional aligners during the prescribed treatment period, all scheduled Invisalign treatment visits, and one set of retainers.

Choose the payment approach that works for you

OPTION 1

Best total value - pay in full

$3,589 total due at the records/scan appointment. Pay by cash, check, card, HSA, or FSA. A card processing surcharge may apply where permitted.

OPTION 2

Hope Dental in-office payment plan

$1,000 down + $517.80 every month for 5 payments. Total: $3,589.
The full balance must be paid within 6 months.

OPTION 3

CareCredit financing

Apply financing through CareCredit. $167/month. No Interest if Paid in Full Within 24 months.
Total: $3,989. (For Staff: ortho rate, ID CC24A006)

OPTION 4

Apply estimated orthodontic insurance

Estimated benefit: $_____ | $3,589 - estimated benefit = estimated patient balance: $_____

Insurance benefits are estimates, not guarantees. Final patient responsibility may change after the carrier processes claims.

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Before you select your payment option

Please review the section that applies to your chosen arrangement. Our team is happy to answer questions before you sign.

OPTION 2

Hope Dental payment-plan acknowledgment

I select the Hope Dental in-office plan totaling $3,589: $1,000 due at the records/scan appointment, followed by five monthly payments of $517.80. I understand that the full balance must be paid within 6 months. I authorize Hope Dental to charge the agreed payment method according to the schedule provided to me. Missed or returned payments may delay treatment or aligner delivery as permitted by the treatment agreement and applicable law.

Patient or responsible party signature _____ Date _____

OPTION 4

Estimated insurance benefit acknowledgment

I understand that insurance coverage is estimated from the information available today and is not a guarantee of payment. If coverage ends, the orthodontic maximum has already been used, the carrier reduces or denies benefits, or the carrier pays less than estimated, I remain responsible for the unpaid balance under my selected payment arrangement.

Patient or responsible party signature _____ Date _____

GENERAL NOTE

The financial terms above address payment only. Clinical eligibility, treatment scope, refunds, cancellation, and patient responsibilities are governed by Hope Dental's separate Invisalign treatment and financial agreements.