**Effective Date:** [DD/MM/YYYY]

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **P. Code**  | **Procedure Description**  | **Standard Fee** | **Insurance Coverage** | **Patient Responsibility** |
|  D001  | Routine Dental Check-up  | $ Amount | $ Amount | $ Amount |
|  D002  | Dental Cleaning | $ Amount | $ Amount | $ Amount |
|  D003  | X-rays (Full Mouth) | $ Amount | $ Amount | $ Amount |
|  D004  | Tooth Extraction | $ Amount | $ Amount | $ Amount |
|  D005  | Filling (Composite) | $ Amount | $ Amount | $ Amount |
|  D006  | Root Canal Therapy (Single Canal) | $ Amount | $ Amount | $ Amount |
|  D007  | Crown (Porcelain Fused to Metal) | $ Amount | $ Amount | $ Amount |
|  D008  | Dental Implant  | $ Amount | $ Amount | $ Amount |
|  D009  | Teeth Whitening  | $ Amount | $ Amount | $ Amount |
|  D010  | Orthodontic Braces (Full Treatment) | $ Amount | $ Amount | $ Amount |
|  D011  | Emergency Dental Care  | $ Amount | $ Amount | $ Amount |
|  D012  | Periodontal Treatment  | $ Amount | $ Amount | $ Amount |
|  D013  | Dentures (Full Set)  | $ Amount | $ Amount | $ Amount |
|  D014  | Dental Sealants  | $ Amount | $ Amount | $ Amount |
|  D015  | TMJ Evaluation and Treatment  | $ Amount | $ Amount | $ Amount |

**Notes:**

1. Standard fee is the regular cost of the procedure without insurance coverage.
2. Insurance coverage indicates the amount covered by the patient's dental insurance.
3. Patient responsibility is the amount the patient is required to pay after insurance coverage.
4. Payment methods: [List accepted payment methods].
5. All fees are subject to change without prior notice.
6. Patients are encouraged to contact their insurance provider for coverage details.
7. For billing inquiries or payment options, please contact [Dental Clinic Contact Information].
8. Discount plans and payment plans are available for qualifying patients.

Please consult with our dental staff for personalized treatment plans and accurate fee estimates.