**LEOFF Board Application for Payment of Services** Case No: _____

**Please Print Clearly & Legibly – Incomplete Form Will Be Returned**

**A) This Section To Be Completed by Member**

Member Name: [redacted]

Member Telepho

Member Address

Alternate Contact

Describe Your Condition and Why It Is Duty Related:

Replace failing bridge #7, 8, 9, 10, 11 with cast partial and extraction #11

Describe the Service/Treatment Requested: Extraction tooth #11 and replace bridge #7, 8, 9, 10, 11 with a cast partial as due to [redacted] is much less expensive than a new bridge and implants.

Total Cost of Treatment/Service: $ 3,455

Amount Paid by Insurance/Medicare: $ none

Amount Requested from the Board $ 3,455

Please attach the Explanation of Benefits statement(s) from your insurance provider(s) and/or Medicare which indicates the amount paid for this treatment/service.

Member Signature: _____ Date: 1/9/26

Please attach a copy of the Power of Attorney if signed by the alternate contact.

**B) This Section To Be Completed by Member's Attending Health Care Provider**
**(attach additional pages as needed)**

Provider's Name: Dr. Madeline Connick Provider's Telephone: 530-541-4405

Clinic/Office Name: South Lake Smiles

Provider's Address: 965 Tahoe Keys Blvd. SLT, CA. 96150

Describe the Patient's Current Condition and State Whether It Is Duty Related:

Patient is missing teeth 7-10. Bridge from 6-11 failed due to decay on 11.

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary:

Tx recommendation is to remove failed Bridge and replace teeth w/ cast RPD. Medically necessary due to decayed abut-ments

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:

only alternative is implants which is much more time consuming + expensive. Pt declined

Provider's Signature: _____ Date: 1-13-26

**Fax Completed Form to: (360) 709-2735 or mail to: City Of Olympia HR Dept, PO Box 1967, Olympia WA 98507-1967**

MADELINE CONNICK D D.S. INC.
965 TAHOE KEYS BLVD.
S LAKE TAHOE, CA 96150
(530)541-4405 x

PRIMARY TREATMENT PLAN

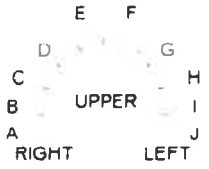
December 30, 2025

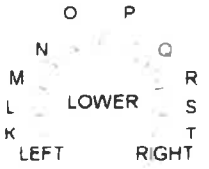


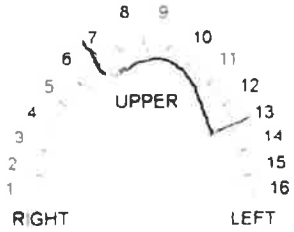


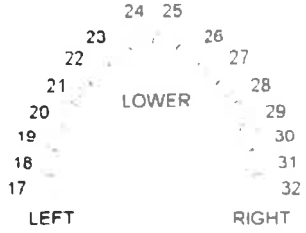
Prepared for: [redacted]

| Group | Planned | Code | Dr | T | Surf | Description | Patient | Insurance | Total | Accepted |
|---|---|---|---|---|---|---|---|---|---|---|
| 2 | 12/16/25 | 5213.00 | 22 | | | Maxillary Partial Denture - Cast | 2,328.50 | 348.50 | 2,677.00 | No |
| | | | | | | Group 2 Totals: | 2,328.50 | 348.50 | 2,677.00 | |
| | | | | | | TOTALS: | 2,328.50 | 348.50 | 2,677.00 | |




**ADDITIONAL COMMENTS**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Insurance | | Dual | X | Single | | None | |
| Primary | 25.00 | Deductible | 577.00 | Y-1-D Used | 1,292.00 | Y-1-D Used Including Treatment Plan | 423.00 Y-1-D Unused |

**Financial Arrangements**

**DISCLAIMER:**

Insurance coverage is estimated - your actual indemnity may be less. You, the patient, are responsible for all amounts not covered by your insurance carrier. Year-To-Date Used Benefits and Remaining Deductible amounts are not affected until the procedure is completed and therefore are not used in this determination of benefits.

**I REQUEST AND AUTHORIZE THE DOCTOR AND/OR SUCH QUALIFIED ASSIGNEES TO PERFORM THE DENTAL WORK LISTED ABOVE.**

Patient Signature _____ Date _____

## LEOFF Board Application for Payment of Services

Case No: _____

**Please Print Clearly & Legibly – Incomplete Form Will Be Returned**

**A) This Section To Be Completed by Member**

Member Name: [redacted]

Member Telepho

Member Address

Alternate Contact

Describe Your Condition and Why It Is Duty Related:

Replace failing bridge #7,8,9,10,11 with cast partial and extraction #11

Describe the Service/Treatment Requested: Extraction tooth #11 and replace bridge #7,8,9,10,11 with a cast partial as clue to [redacted] is much less expensive than a new bridge and implants.

Total Cost of Treatment/Service: $ ~~XXXXXXX~~

Amount Paid by Insurance/Medicare: $ none

Amount Requested from the Board $ 3455

$379.54 Total $3,834.54

Please attach the Explanation of Benefits statement(s) from your insurance provider(s) and/or Medicare which indicates the amount paid for this treatment/service.

Member Signature: _____ Date: 1/9/26

Please attach a copy of the Power of Attorney if signed by the alternate contact.

**B) This Section To Be Completed by Member's Attending Health Care Provider**
**(attach additional pages as needed)**

Provider's Name: Rachel Appelblatt Provider's Telephone: (530) 541-4042

Clinic/Office Name: Tahoe Oral Surgery & Implant center

Provider's Address: 591 Tahoe Keys Blvd #D4, S. Lake Tahoe, CA 96150

Describe the Patient's Current Condition and State Whether It Is Duty Related:

Caries tooth #11 and not duty related

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary:

Surgical extraction of tooth #11 with bridge sectioning at tooth #6.

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:

No.

Provider's Signature: _____ Date: 1/13/2026

**Fax Completed Form to: (360) 709-2735 or mail to: City Of Olympia HR Dept, PO Box 1967, Olympia WA 98507-1967**

Revised 12/27/07

Location: \\Calvin\Personnel\Forms\

# TAHOE ORAL SURGERY AND IMPLANT CENTER

## Treatment & Financial Plan

December 23, 2025

Prepared for: [redacted]

Navigating the dental and medical benefit world is confusing in the best of times and maddening at its worst. Our treatment coordinators have a wealth of knowledge in dealing with these companies and will make every effort to coordinate your benefits on your behalf. Please keep in mind the following is an approximation or your benefits and you are responsible for any outstanding balance.

| Description | Th# | Fee |
|---|---|---|
| Limited Oral Eval - Problem Focused | | 124.00 |
| Panoramic Film | | 0.00 |
| **Total for no phase** | | **124.00** |
| Surgical Extraction | 11 | 386.00 |
| Fixed Partial Denture Sectioning | 6 | 268.00 |
| **Total for Phase One** | | **654.00** |
| **Total** | | **778.00** |

| | |
|---|---|
| **Total fee for above procedures:** | **$778.00** |
| Scheduling Deposit: | -$189.00 |
| Amount due day of Surgery: | $589.00 |

These fees will not change for six months from this date.

**If you have a benefit plan that pays a portion of the services provided:**
Payment of your deductible (if applicable) as well as an estimate of your share of the fee is due at the time of service. If your benefit plan pays more or less than the estimated amount you will be reimbursed or billed accordingly. You will be billed for any outstanding balance 30 days from the date of service if payment in full has not been made by the insurance carrier. Thereafter a 1.5% per month finance charge will be assessed.

**If you do not have a benefit plan that covers the services performed:**
Payment is due at the time of service.

**Surgery Scheduling:**
**10% of the surgical cost (minimum $25) is due at the time of making the appointment for surgery. Our surgery schedule often changes and we will confirm your surgical time 48 hours prior to the day of your procedure.**

**Cancellation Policy:** Cancellation or rescheduling a surgery appointment without 48 hours notice will incur a $100 fee.

Payment plans are available; please ask our treatment coordinators for further information.

***A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.***

***If your account becomes delinquent (past due), we may take the following actions: (1) refer your account to a collection agency, (2) file a lawsuit to recover the amount owed. If your account is referred to a collection agency, you agree to pay a collection fee and interest at an annual rate of 10% on the unpaid balance, beginning 30 days after the date of service. If legal action is required to collect the amount owed, you agree to pay all reasonable attorney's***

***fees and court costs incurred in the collection process, in addition to the outstanding balance, collection fees, and interest.***

**I agree that, in order for Tahoe Oral Surgery and Implant Center, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Tahoe Oral Surgery and Implant Center or EBO Servicer and collection agents may contact me by telephone or text message at any telephone number, without limitation of wireless, I have provided or Tahoe Oral Surgery and Implant Center or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.**

**By providing my email address, I understand and agree to receive communications by email from Tahoe Oral Surgery and Implant Center, and collections agents to service my account or to collect any amounts I May owe. I understand that work or government email addresses may be monitored by third parties, and if I do not provide a personal email address, I consent to any potential third party disclosure of my information.**

I have read and understand the above arrangements and agree to be responsible for payment of services rendered.

Signed_____ Date_____

In compliance with the Federal Truth in Lending Act, the following disclosures are made to our patients:

1. Pay the entire amount of the balance within 60 days from the date of service and there will be no finance charge.
2. You will be charged a finance charge of 1.5% per month which is an annual interest rate of 18% on any balance.
3. Balances over 90 days are subject to a minimum finance charge of $1.00.

# Invoice

dandy

| | |
|---|---|
| Invoice number | #94882-6564-004 |
| Date of issue | February 1, 2026 |
| Date due | February 8, 2026 |
| Status | Open |

**ZIMA INTERNATIONAL, INC.**

P.O. Box 738550

Dallas, TX 75373-8550

(866) 310-8665

BillingandCollections@meetdandy.com

**South Lake Smiles**

965 Tahoe Keys Blvd.

South Lake Tahoe, CA 96150

mconnick@southlakesmiles.org

## $9,597.48 due February 8, 2026

Powered by Dandy Hardware

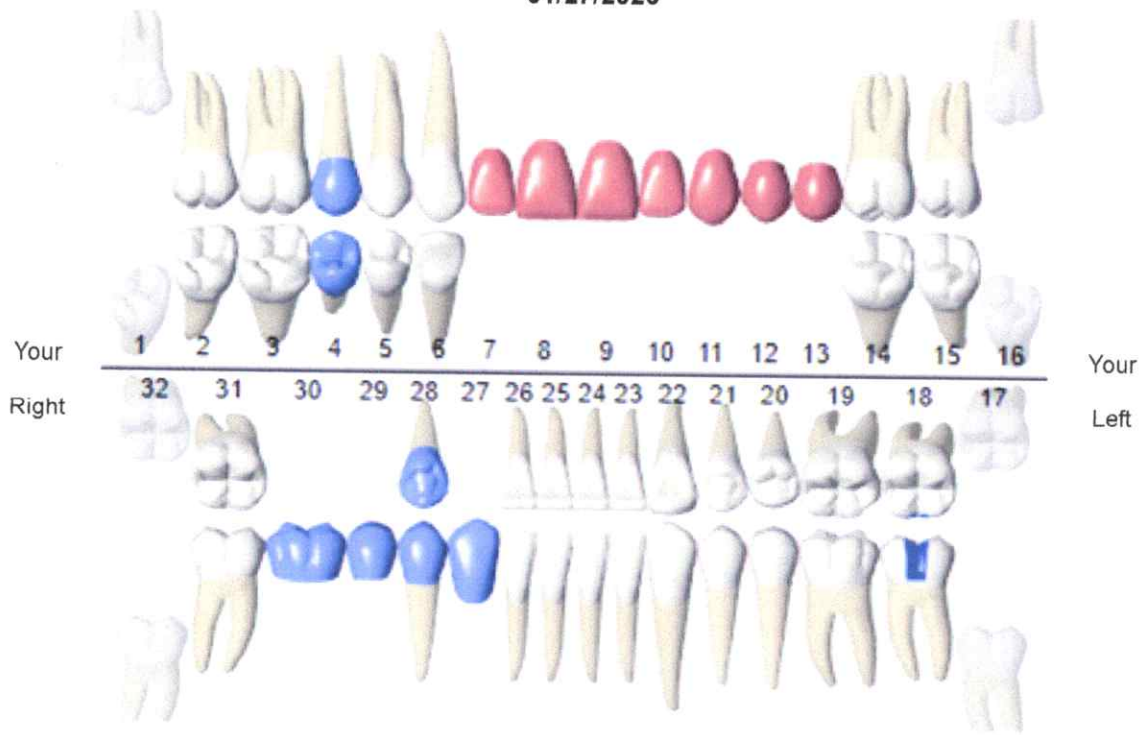
| | | |
|---|---|---|
| Orders | 32 | $8,825.00 |
| Sales Tax | | $772.48 |
| Total Balance | | $9,597.48 |

### Lab Work

| Date | Description | Doctor | | Price | Tax | Total |
|---|---|---|---|---|---|---|
| 01/29/2026 | Terry, Poole | Madeline Connick | Open Order → | $349.00 | $30.54 | $379.54 |
| | Partial Denture 6-13 - Titanium | | | $349.00 | | |
| | Removable Model - Dual Full Arch | | | $0.00 | | |
| 01/29/2026 | [redacted] | Madeline Connick | Open Order → | $99.00 | $8.67 | $107.67 |
| | Crown 18 - Zirconia Monolithic | | | $99.00 | | |
| 01/29/2026 | [redacted] | Madeline Connick | Open Order → | $99.00 | $8.67 | $107.67 |
| | Crown 3 - Zirconia Monolithic | | | $99.00 | | |
| 01/27/2026 | [redacted] | Madeline Connick | Open Order → | $99.00 | $8.67 | $107.67 |
| | Crown 31 - Zirconia Monolithic | | | $99.00 | | |
| 01/27/2026 | [redacted] | Madeline Connick | Open Order → | $140.00 | $12.25 | $152.25 |
| | Bleaching Tray - Both | | | $140.00 | | |
| 01/27/2026 | [redacted] | Madeline Connick | Open Order → | $398.00 | $34.83 | $432.83 |

# Active Treatment Plan

**Madeline Connick DDS, Inc**
**(530)541-4405**
**TERRY POOLE, DOB 08/13/1942**
**01/27/2026**




Existing Complete Referred Out Treatment Planned

| Done | Priority | Tth | Surf | Code | Sub | Description | Fee | Allowed | Pri Ins | Sec Ins | Pat |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | P-01 | | | D5820 | | interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary #11<br>Pri Deduct Applied: $25.00 | 733.00 | 0.00 | [redacted] | 0.00 | [redacted] |
| | | | | | | **Subtotal** | **733.00** | **0.00** | [redacted] | **0.00** | [redacted] |
| | P-02 | | | D5213 | | maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) #7-13<br>Over annual max | 2677.00 | 0.00 | [redacted] | 0.00 | [redacted] |
| | | | | | | **Subtotal** | **2677.00** | **0.00** | [redacted] | **0.00** | [redacted] |
| | | | | D0140 | | limited oral evaluation - problem focused<br>Over annual max | 103.00 | 0.00 | 0.00 | 0.00 | 103.00 |
| | | | | D0220 | | intraoral - periapical first radiographic image<br>Over annual max | 50.00 | 0.00 | 0.00 | 0.00 | 50.00 |
| | | | | D9999 | | unspecified adjunctive procedure, by report<br>Over annual max | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | | | | | | **Subtotal** | **153.00** | **0.00** | **0.00** | **0.00** | **153.00** |
| | | | | | | **Total** | **3563.00** | **0.00** | **1000.00** | **0.00** | **2563.00** |

$3410 00

## Family Insurance Benefits

| BenefitName | Primary | Secondary |
|---|---|---|
| Family Maximum | | |
| Family Deductible | 50.00 | |

## Individual Insurance Benefits

| BenefitName | Primary | Secondary |
|---|---|---|
| Annual Maximum | 1000.00 | |
| Deductible | 25.00 | |