Limoli and Associates
PO Box 899
Arlington, TN 38002-0899

LIMOLI & ASSOCIATES

It's time to update your fee schedule

Mail or fax:
Limoli and Associates
PO Box 899
Arlington, TN 38002-0899
1-800-344-2633
www.LIMOLI.com

Make checks to
Limoli and Associates.
Payment must accompany all orders.

Let Limoli and Associates update your personal fee data for your service area. Our Comprehensive Fee Schedule Review is available for individuals, as well as group dental practices. Our comparative analysis of your submitted fee data will be used to compile a seven-page report detailing 223 of the most often performed dental procedures.

The analysis includes the comparison of your existing fee to data compiled for your ZIP code. Your updated report will be color-coded to easily alert you to areas where you exceed or fall below your area competitors, and to indicate new, deleted or changed codes.

Starting the process is easy. Just sign the Confidentiality Statement on the back of this letter and complete the following:

_____**Comprehensive Fee Schedule - $365.**

_____**Comprehensive Fee Schedule + Code Manual - $499.**

Name: _____

Address: _____

City/State/ZIP: _____

Phone: _____ Fax: _____

Signature: _____ Email Address (Optional): _____
(Your email address will not be shared with others. See our privacy and refund policy at www.LIMOLI.com.)

Method of Payment: ☐ **Check#_____** ☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER** ☐ **AMEX**

Acct. No.: _____ Exp. Date: _____

CVV2 number: _____ (3digits after card number on signature strip (VISA/MC) 4 digits on AMEX, upper right, front of card.)

Billing address of card (If different from shipping): _____

PO Box 899 Arlington, Tennessee 38002-0899
(800) 344-2633 phone & fax
www.LIMOLI.com

Confidentiality Statement

This Confidentiality Agreement must be signed before we can evaluate your fee schedule(s). In addition to restricting the use and disclosure of our proprietary and confidential business information, this agreement is both a reminder and a commitment not to use the information that we provide in any manner that would violate federal or state antitrust laws.

I/We, the undersigned, acknowledge that the information provided by Limoli and Associates in response to this request is the property of Limoli and Associates, and is provided for my/our personal office use only. I/We agree not to disclose it to any other person, and further agree not to reproduce or transmit any part of it in any form or by any means, including photocopying, facsimile transmission or entry into any electronic information storage and retrieval system. I/We also agree that the information will not be discussed with any other dentist or dentist's representative, and will not otherwise be used in any manner that could violate federal or state antitrust laws.

Name of Requesting Individual, Group Practice, or Corporate Entity (please provide a list of office locations and dentists you represent)

Name:_____ Date Submitted: _____

Address:_____

City/State/ZIP: _____ Phone: _____

Dr. _____ Date: _____
Signature

Dr. _____ Date: _____
Signature

If requester is a business entity employing or otherwise representing dentists, please sign here. Your signature affirms that you are authorized to sign this agreement on behalf of your organization and each person who will have access to the information provided to you by Limoli and Associates.

By:_____ Date:_____
Signature

Title: _____

Please Note: We ask that you submit your entire, unrestricted fee schedule. This form must be signed before your review can be completed. Any information furnished will be used as collective statistical data only and will never be singularly identified. If you have any questions, please call our office.