Contract for Orthodontic Services with _____

Patients Name: _____ Office: _____ Date: _____

_____ & Orthodontics will provide Orthodontic Services to the patient listed above with the Permission of the parent or legal guardian. A more complete description of those services is described in the client's office record maintained at the professional office.

Treatment Fee	$
Additions / Upgrades	$
Account Management Fee	$
Insurance Payment Expected*	$_____
Total:	**$**
Down Payment/ 1st Installment	$_____ Paid ___/____/_____
Total Unpaid Patient Share	**$**

The responsible party hereby agrees to pay _____ & Orthodontics the total unpaid patient share listed above as follows: _____ monthly payments of $_____.

- ✓ All subsequent installments are payable on the first of each month consecutively until paid in full.
- ✓ All payments are without interest.
- ✓ In the event that treatment is completed earlier than originally expected, the remaining patient share is due prior to the removal of braces.

Patient's with Insurance: If for ANY reason the responsible party's insurance, _____, fails to pay the total estimated amount, such as for ineligibility; and you have a balance for which the insurance does not cover, you will be responsible for the unpaid insurance balance due. Note that insurances usually pay quarterly throughout treatment.
____ Initial

1. **Treatment Fee**: The orthodontic fee covers initial & final records, all standard appliances (braces, color elastics or wires, etc.) and adjustments/ visits necessary to complete this phase of expected orthodontic treatment. Additional charges may apply for additional time or visits due to factors outside the doctor's control, such as poor patient cooperation, missed and/or cancelled appointments, lack of appliance or elastic wear, etc. One clear retainer per arch treated is included in the treatment fee.
2. **The Fee Does Not Include**: General dentistry, regular checkups, fillings, surgery, cleaning of teeth, extractions, partials to replace missing teeth or crown & bridge work, Etc., which may be necessary during the course of treatment are at an additional fee and are not included in this contract.
3. **Additional Fees**: Our office charges additional fees for all replacement appliances or retainers and breakage of orthodontic bands or brackets as follows: $300 appliance replacement, up to $____ each for retainers and $__ per bracket or band. Note that all breakage appointments are made in the morning.

_____ _____
Responsible party Signature Treating Orthodontist Signature

_____ _____
Responsible Party (please print) Date

Orthodontic Policies

_____ 1. **Payments:** The fee is due monthly for your budgeting convenience. Treatment appointments vary, but usually average 6-8 weeks apart. There is no relationship between the number of monthly visits and monthly payments.

_____ 2. **Discontinuing treatment**: in the event the patient should move or want to discontinue treatment, the fee will be adjusted accordingly with our prorated formula. *Please note the initial records fee is not fully reimbursable if the client fails to start treatment.*

_____ 3**. Transfer requests**: if you move and requesting records, a single duplication will be furnished for fee no more than $50. If you would like to transfer locations within our practice you may do so one time at no cost, any additional transfers will incur a $___ fee.

_____ 4. **Delinquent payments**: if the payment becomes repeatedly delinquent or in excess of 90 days past due, the office and doctor reserve the right to either dismiss the patient from the practice or remove all braces with or without retainers, all without liability for the unfinished treatment. The account balance must be paid in full at the completion of treatment or braces may not be removed.

_____ 5. **Missed appointments**: We assume no responsibility for missed appointments and it is the client's responsibility to reschedule an appointment. We do not routinely confirm appointments. If appointments are repeatedly missed, not made or cancelled, treatment will be discontinued and client dismissed.

_____ 6. **Orthodontic results**: The final orthodontic results are usually very successful. However, there is no such thing as a perfect smile or perfect bite. It is normal for teeth to move back to their original position, even after wearing retainers for the prescribed time, in many case retainers must be worm for a lifetime. Retainers must be worn for the recommended time as the orthodontist has advised. The orthodontist will do his/her best in each individual case.

_____ 7. **Retreatment:** if for any reason the braces have to be placed again there will be an appliance replacement charge and retreatment fee assessed.

_____ 8. **Options and limitations**: my options for treatment have been fully explained to me along with the risks, benefits and limitations for my particular case. I acknowledge results are based on my dentition as well as my cooperation.

_____ 9. **Retention:** the patient will be seen in retention after treatment is complete to check retainers for up to one year or a maximum of four appointments at no charge. After that the patient may continue to be seen for retention checks however a $____ fee will be assessed per visit.

I hereby certify that I have read and received a copy of the above disclosure statement on this date _____. I understand and agree to abide by the official policy as stated above.

_____ _____

Responsible party signature Treating orthodontist signature

_____ _____

Responsible party name (please print) Witness signature (orthodontic staff)