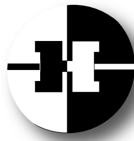

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Federal Truth and Lending Disclosure Statement

for Professional Orthodontic Services

Patient Name: ______________________________ Date: ______________

Treatment (Tx): ______________________________ Est. Tx time: ______________

Fee for orthodontic treatment ______________

Fee for orthodontic records ______________

$______________ *(subtotal 1)*

Estimated insurance payment (–) ______________
(If, for any reason the estimated amount is not paid by your insurance company, it becomes your obligation.)

$______________ *(subtotal 2)*

Sibling or other discount (–) ______________

Total patient responsibility $______________

❑ **Payment in full** (5% credit)
Previous total – 5% (______________) = New total $______________

❑ **In-Office payment plan**
(–) Downpayment of $______________ (_____%) = Balance $______________
w/monthly installments of $______________/________months
and one final payment of $______________.
- Autodebit from a checking, savings or credit card account and based on approved credit

FEES: Treatment fee includes regular office visits, appliances and a first set of retainers with 24 months of retainer follow-up visits. A fee will be charged if longer retainer follow-up care is necessary. Excluded in the fee are appliances lost or repaired due to patient negligence, missed appointments and charges for general dentistry, surgery or X-rays.

INSURANCE: We will provide assistance in billing your insurance, but you remain accountable for the full treatment fee and timely payments. If the insurance carrier fails to pay in a timely manner we will request that you bring your contract current and contact your insurance company.

PAYMENTS AND PAYMENT SCHEDULE: Frequency of office visits has no bearing on monthly payments, which are due 1x per month on the 1st of each month and late on the 15th. The fee is for total services rendered and does not correlate to the length for complete treatment since actual treatment time may be shorter or longer than the payment period.

ADDITIONAL CHARGES: Any checks returned for insufficient funds and/or missed appointment will be assessed a $35 fee.

GENERAL CARE: During orthodontic treatment the patient will need to see a general dentist at least once every 6 months for a cleaning, exam, gum tissue care, or other dental needs. General dental upkeep and hygiene are necessary to achieve a successful orthodontic result.

PATIENT COOPERATION: At the time of appliance removal the fee may need to be paid in full. If cooperation is poor, extenuating circumstances occur, or payments are not made in a timely manner, we reserve the right to remove appliances prior to the completion of care. Treatment time exceeding 120 days past the estimated timeline will be assesed a fee of $150/month until treatment is finalized.

Our desire is to provide quality care in a warm, caring and professional manner. If you have any questions, comments or issues, please let us know so that we can serve you better.

I hereby acknowledge that I have read and I understand these financial arrangements and I agree to make the payments as outlined.

______________________________ ______________
(signature of financially responsible party) (date)

______________________________ ______________
(printed name) (witness)

______________________________ ______________
(address) (telephone #s)