ORTHODONTIC CLEAR ALIGNER TREATMENT CONTRACT/INFORMED CONSENT ("Contract")

PATIENT NAME:_____CHART #_____OFFICE # _____

Orthodontic program for_____months of active treatment:

Orthodontic Treatment Fee:		$_____	Usual & Customary Fee $_____
Dental Plan Membership Fee	+	$_____	
Additional Charges*	+	$_____	
TOTAL ESTIMATED COST		$_____	
Estimated Insurance Benefit**	-	$_____	
Down Payment (if applicable)	-	$_____	
TOTAL PATIENT BALANCE		$_____	

***Additional charges may apply for in the event that supplemental orthodontic appliances or therapies are needed.*
****Estimated Insurance Benefit is subject to the type and amount of your insurance coverage and your continued coverage may be a condition to receiving the full benefit.*

REVEAL ORTHODONTIC ALIGNER TREATMENT includes diagnostic records, the required sets of aligners, and final records. This also includes one set (top and bottom tray) of retainers; additional sets are provided for an additional fee. Refinements to the original case may result in additional fees. **NOTE: THE TOTAL PATIENT BALANCE IS 75% REFUNDABLE UNTIL THE ALIGNERS ARE ORDERED FOR MANUFACTURING. ONCE THE ALIGNERS ARE ORDERED FOR MANUFACTURING, THE TOTAL PATIENT BALANCE IS NONREFUNDABLE.** The Total Patient Balance does not include any general dentistry treatment such as fillings, extractions, cleaning, bonding, the services of an oral surgeon, periodontist, speech or myofunctional therapist, or any other dental specialist.

PAYMENT PLAN OPTIONS: Check Selected Option

☐ Payment in Full: Total one-time payment $_____

☐ Third Party Financing Option: Application and approved credit required

☐ Smile Brands Finance: Application required

Failure to pay timely will result in maintenance checks while active treatment is suspended. Continued failure will result in dismissal.

There may be an increased demand for afternoon appointments and consequently, availability may be limited. We will try to accommodate specific appointment requests. Patients that arrive more than 15 minutes late to their appointment time may be required to reschedule their appointment and may be charged a missed appointment fee.

ADDITIONAL CHARGES:

Added treatment visits beyond estimate	$_____	Replacement aligners	$_____per tray
Retainer visits (after treatment)	$_____	Replacement retainers	$_____
Records duplication or transfer	$_____	Other: _____	$_____

THE TREATMENT PROCESS. The doctor will examine the patient and advise on the potential treatment plan. Diagnostic x-rays and other records will be required to diagnose and determine the appropriate treatment plan ("Treatment Plan"). **NOTE: A GENERAL DENTAL CHECK-UP AND NECESSARY DENTAL WORK MUST BE COMPLETED PRIOR TO PLACEMENT OF ORTHODONTIC APPLIANCES/ALIGNERS.** Once appliances/aligners are placed, the patient (or patient's responsible party) will need to schedule periodic appointments to adjust the appliances/aligners and monitor progress (typically in 6-8 week intervals). **NOTE: THE DOCTOR WILL REQUIRE GENERAL DENTAL CHECK-UPS EVERY SIX MONTHS AND COMPLETION OF ANY NECESSARY DENTAL TREATMENT(S).** Patients will be given written progress reports (typically at six month intervals) of treatment status and identify any necessary changes to the Treatment Plan. The doctor will be available for consultation with the patient/responsible party upon request. Progress records may be required during treatment to help monitor progress. When treatment goals are achieved, final records will be provided and retainers placed as needed.

Failure to follow the doctor's instructions will adversely affect the doctor's ability to treat the patient to the best achievable result within the diagnosed treatment term. Should cooperation become an issue, the doctor may request a conference with the patient/patient's responsible party to determine the corrective action. Additional instances of non-cooperation may result in the issuance of a Statement of Non-Responsibility and call for the patient to be placed in retention even though treatment is incomplete. Any and all costs of completing orthodontic treatment with another doctor will be solely the patient's responsibility. **NOTE: ORTHODONTIC ALIGNER FEES ARE NOT BASED ON THE NUMBER OF MONTHS OF TREATMENT, THE NUMBER OF VISITS, OR APPOINTMENTS KEPT.**

All the terms and conditions of this Contract are hereby incorporated by reference, including, but not limited to, the following:

1. The allowance for insurance benefits is only an estimate, the actual amount will depend upon your insurance company and the type and amount of your coverage. The patient and/or responsible party are liable for the entire amount of the treatment less any payments made by the insurance company. Insurance benefits are paid over the treatment term; therefore, to receive your maximum insurance benefit, you must remain covered.

2. This Contract applies only to the original estimated treatment term and scope of the Treatment Plan. The patient will be financially responsible for additional treatment beyond the original active treatment term and scope of the Treatment Plan if needed to accomplish the treatment goals.

3. EARLY TERMINATION: In the event the patient/patient's responsible party elects to discontinue treatment before the completion of the Treatment Plan, patient/patient's responsible party will nonetheless remain financially responsible for the costs as set forth above unless otherwise determined by the dental plan guidelines. Except as specifically set forth in this Contract, all payments made by patient/patient's responsible party are non-refundable.

By signing this Contract, patient/patient's responsible party acknowledges and affirms that they have (i) read and understand the Contract, (ii) consulted with or had the opportunity to consult with legal counsel of their own choosing, (iii) agreed to all of the terms of the Contract voluntarily, and (iv) received a copy of the Contract.

I have read and understand all of the above and agree to abide by the requirements and restrictions defined herein and by the doctor. I further agree to make the payments as specified above. I hereby consent to and request the initiation of orthodontic treatment for my child/self and authorize the treating doctor to do whatever procedures they deem necessary during treatment.

Patient Name_____ Responsible Party _____

Pt. Signature_____ Resp. Party Signature _____

Address_____ City, State, Zip _____

Telephone No._____ Soc. Sec. No. _____

Signature_____ Date _____

Prepared by: _____

NOTICE TO SIGNER:

Do not sign this agreement before you read it or if it contains any blank spaces. You are entitled to a completed copy of this agreement.