EXPLANATION OF THE FEES FOR ORTHODONTIC TREATMENT

The following is an agreement for orthodontic treatment for:

__________________________  ________________
patient's name                date

Please read this explanation carefully. Feel free to ask any questions you may have about the treatment or finances.

I. FEES:
   A. The total fee for orthodontic treatment is $ __________________

      Records Fee   $ ______________ (due when records are taken)
      Initial Fee   $ ______________ (due when appliances are placed)
      Monthly Fee   $ ______________ (due by the tenth of each month)
      Retention Fee $ ______________ (due when retainers are delivered)

   The records fee is due when the records are taken. The initial fee is due when appliances are placed. The monthly fee is due by the tenth of each month. A late charge of 1.5% per month will be assessed on accounts thirty days or more in arrears. Office policy requires that an account be current prior to the removal of appliances. This fee is valid for ninety days.

II. WHAT THIS COVERS: The fee for orthodontic services covers the active, tooth movement phase of orthodontic treatment. This usually runs from twelve to twenty-four months. In addition, the fee covers twenty-four months of retention or observation. For recall or observation visits following the retention period, the prevailing office visit charge will apply.

III. WHAT THIS DOES NOT COVER: Additional fees will be incurred for:
   • broken braces.
   • broken appointments.
   • lost or broken appliances (eg., headgear, retainers).
   • extension of treatment time due to poor patient cooperation or failure to follow instructions.
   • unpredictable growth complications requiring extended treatment

IV. ORTHODONTIC INSURANCE: The patient or responsible party is solely responsible for treatment fees. We will assist you in filling out and filing all necessary insurance forms. You may choose to have the insurance assigned to our office or to receive the insurance payments yourself; however, all services are charged directly to the patient.

__________________________  ________________
Signature of Parent/Responsible Party                Date