

PRACTICE FINANCIAL POLICIES

PATIENT: _____

FINANCIALLY RESPONSIBLE PERSON: _____

THIS FINANCIAL POLICY is in effect for an Orthodontic treatment that will take APPROXIMATELY _____ months. At the end of this time there will be a Retention Phase of treatment that will take approximately _____ years. *IF THERE IS EXCESSIVE BREAKAGE* of the braces or loss of removable appliances, retainers, etc., there may be repair or replacement charges to be determined at that time and/or result in extended treatment time.

IF SERVICES ARE TERMINATED for any reason before the completion of treatment, the account will be adjusted and a just settlement determined, based on the amount of treatment completed.

SERVICES PROVIDED BY OTHERS, Laboratories, etc., outside of this orthodontic practice are not part of the treatment fee.

IF ORTHODONTIC INSURANCE covers all or part of the fee, it may be paid directly to the practice or to the policy holder as arranged. Whatever part of the account balance not paid directly to the practice by an insurance company must be paid by the Financially Responsible Person noted below.

FINANCIALLY RESPONSIBLE PERSON

DATE

IF A THIRD PARTY not residing with the patient is responsible for the account balance and this third party, defaults on payment, the person named below will take full responsibility for the balance of the account.

PERSON ACCEPTING THIS RESPONSIBILITY

DATE

SIGNATURE ON FILE

I hereby consent to the taking of x-rays, photographs and other necessary records before, during and after treatment and to the use of same by this practice for scientific papers and demonstrations.

RESPONSIBLE PERSON

DATE

I also authorize the release to my insurance company or companies any information including the diagnostic records and diagnosis of any treatment required to comply with applicable law and facilitate the billing and reimbursement for the treatment provided.

INS. Co. _____ Group #: _____ INS. Co. _____ Group #: _____

Employed By: _____

SIGNATURE OF PARTY #1

DATE

INS. Co. _____ Group #: _____ INS. Co. _____ Group #: _____

Employed By: _____

SIGNATURE OF PARTY #2

DATE