OFFICE POLICIES
FOR ORTHODONTIC TREATMENT

Initial Each Line:

INSURANCE AND FINANCIALS

_____ ***Contract payments are due on the 1st day of each month.*** *There is a 7-day grace period for late payments.*

_____ ***Any unpaid insurance balance is the patient's responsibility and must be paid before appliance removal.***

_____ Insurance co-pays are the patient's responsibility. If your insurance changes, you must inform us, and any unpaid balance will be the patient's responsibility. If you change insurance and do not inform us, you may incur extra fees.

_____ We reserve the right to refuse to process/accept insurance benefits at any time.

_____ If you transfer during treatment, your account will be pro-rated and the account will be settled prior to sending your records to your new orthodontist.

ADDITIONAL FEES

_____ *There is a $25 fee for:*

- Missed appointments
- Appointments that are not cancelled 24-hours in advance
- Broken brackets that are not returned to the office (if returned, the fee is waived)
- Returned checks or non-sufficient funds on all transactions

_____ There may be extra charges for extended treatment due to lack of cooperation or insurance coverage.

_____ You will receive one set of retainers. If you require new retainers for any reason, there may be a fee.

APPOINTMENTS

_____ ***All patients arriving more than 30 minutes late to their appointment time will be rescheduled.*** *The last appointment of the day will be rescheduled if arriving more than 15 minutes late.*

_____ Some appointments may be scheduled during school/work hours. We understand that this can be inconvenient. However, sometimes this is required to achieve the best possible treatment outcome.

_____ Missed/cancelled appointments are the patient's responsibility. We are not responsible for missed or forgotten appointments. It is up to the patient to schedule his/her own appointments on a timely basis.

DENTAL CARE

_____ General dental care is the patient's responsibility. We advise patients to see their general dentist every 3 months during orthodontic treatment. Please notify us of any changes to your dentist/medical history.

_____ If I do not cooperate with my treatment plan (including missing appointments, not wearing elastics, not having proper oral hygiene, breaking appliances, etc.), my doctor may ask me to sign a compliance letter.

_____ _____ _____

PRINT Patient Name SIGNATURE of Patient/Parent/Guardian DATE