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AffordableBraces.com, PA & ClearSmilesATLANTA.com

Orthodontic Treatment Agreement

Patient's Name: _____ Acct #: _____

Your Active Orthodontic Treatment Includes:

- (1) Evaluation of orthodontic diagnostic records, case analysis and treatment planning
- (2) Impressions, fabrication and application of Invisalign Appliances
- (3) Periodic orthodontic adjustments and checkup visits as necessary up to 24 months. *Maximum Treatment Time
- (4) Invisalign Treatments: Refinement or mid-course correction appliances / Limited to **one** additional set of aligners, if required
- (5) Any emergency appointment during orthodontic treatment
- (6) Progress communication during treatment with patients, parents, dentists and specialists
- (7) Cosmetic tooth reshaping during and at the end of treatment (if necessary)
- (8) Clear retainers: Additional fees are charged for lost aligners, Hawley Retainers and lost or broken retainer(s) **Initials** _____

Your Treatment Does Not Include:

- (1) Check-up appointments after first retainer(s) are placed for 1 to 3 retention visits per year
- (2) Retention check-up appointments (after active treatment is completed) will cost \$50 per visit
- (3) Retainer repairs, replacements; excessive breakage or loss of orthodontic appliances using charged at \$25 per broken bracket
- (4) Fillings, cleanings and extraction(s) of teeth (General Dental or Other Specialist Procedures)
- (5) Our orthodontists are not Primary Care Dentists. You agree to visit your PCD every 6 months or more.
- (6) **If braces are recommended to enhance or finish your Invisalign case there will be an additional fee of \$150/month (10 month minimum)**
 You were quoted the lowest fee for Invisalign treatment without applying braces. Most cases will not require braces. **Initials** _____

Your Appointments: *Advance notice of 24 hours is requested to cancel an appointment.*

We attempt to schedule all appointments at your convenience. However, some appointments require early morning or afternoons to allow us to perform longer procedures during a less busy time of our day. We will see you on an emergency basis without a scheduled appointment to make you comfortable and avoid unnecessary delays in treatment. **Initials** _____

Fee Protection:

Generally active treatment is completed within the prescribed time. However, if treatment extends beyond the *Maximum Treatment Time for any reason, there will be a monthly fee not to exceed **\$150** until treatment is completed or the braces are removed. In the event your case involves impacted teeth including, but not limited to, 12-year molars and/or upper or lower canines, you will be charged for additional months of active treatment required to resolve the problem. In some cases we may recommend the removal of teeth that have a poor prognosis. You will be informed if any of the aforementioned problems arise. If a removable appliance is lost or broken, there will be a charge of **\$300** for each replacement appliance. **Initials** _____

Transfer During Treatment:

If transfer to another city interrupts treatment and your account is current your treatment agreement will be voided. Minimum startup charges for diagnostic records, case work-up, Invisalign Clincheck and Invisalign Aligner Fabrication are **\$3,600**. Cases that are prepaid will be prorated for treatments rendered. A refund of unearned fees will be forwarded to your new orthodontist or paid directly to you upon request. Duplication of orthodontic records and case summary to the new doctor(s) has a fee of \$75. **Initials** _____

Insurance Assignment:

When you execute this agreement you agree to be responsible for all orthodontic fees and unpaid insurance benefits if our office agrees to accept assignment of benefits. When insurance benefits are verified and our office accepts assignment, the responsible party agrees to pay any unpaid insurance fees. We computer generate insurance forms, necessary correspondence, and file your insurance at No Charge. The administration of your benefits as they pertain to this treatment is your responsibility. You as the policyholder have more influence with the insurance companies to assure timely payment of your orthodontic benefits. In the event your insurance carrier does not initiate payment of orthodontic benefits within 90 days, your monthly payment will be adjusted to reflect unpaid insurance. Delinquent accounts of 60 days or more will necessitate discontinuing active treatment until account is brought current.

When you execute this agreement you agree to be responsible for all orthodontic fees and unpaid insurance benefits. **Initials** _____

ORTHODONTIC FEES **NO INTEREST PAYMENT PLAN** (*Recurring Payments Only*)

\$0000.00 Invisalign *8% discount if paid in full by check, money order or cash on Visit One; 5% discount for credit card pmts*
 -\$ Insurance Amount *Estimated Insurance Benefits (Pending written verification of orthodontic benefits)*
\$0000.00 *Your account total less any insurance benefits. Your account balance to be paid by Care Credit**

Orthodontic Services	Fee	When Due	Number of Pmts
Diagnostic Records (Photos, X-rays, Models)	\$0000.00	Visit One	1
Invisalign Impressions	\$0000.00	Visit Two	1
Monthly Amount Drafted From Your Account*	\$000.00	Monthly	10

**All payments must be received by no later than the 10th of each month to avoid a \$15 billing fee
 There is a \$25 charge for returned checks and for declined drafts*

X _____ X _____ DATE _____
RESPONSIBLE PARTY(S) **WITNESS OR NOTARY**

THIS PAYMENT PLAN MAY BE MODIFIED IN 90 DAYS IF INSURANCE PAYMENTS ARE NOT RECEIVED