AGREEMENT TO ORTHODONTIC TREATMENT

Patient Name: ____

Responsible Party Name: ____

Relationship to Patient: ____

I hereby certify that:

- I have read and received a copy of this document containing the fee agreement and payment plan.
- I consent to the treatment outlined.
- I acknowledge my responsibilities for payments and agree to pay Dr Chris Dimos the total payments stated in this agreement. I understand that full payment has to be made prior to completion of orthodontic treatment.
- I understand that if the account becomes in arrears and I have not made any payment arrangements with Dimos Dental, treatment may be ceased.
- I understand that if any debt collection fees are incurred, I will be liable for these fees.
- I understand there **may** be additional fees for lost or broken appliances and agree to pay these fees, if charged.
- Oral hygiene is an important part of Orthodontic treatment. We advise seeing our Oral hygiene department at least 3-4 monthly to maintain your oral health.
- I have read and accept the above terms.

Responsible Party Name: ____

Responsible Party Signature: ____

Date: ____________________

Please sign this agreement and return it to our clinic with the initial payment, on or before the patient's first treatment appointment.

FEE AGREEMENT FOR ORTHODONTIC TREATMENT

Patient Name: ____

Responsible Party Name: ____

Residential Address: ____

____

Treatment description: ____

Treatment Item No.: ____

☐ Payment in full

Total treatment fee: $________________

Payment due date: _________________

☐ Payment plan

Total treatment fee: $________________

Initial Deposit: $________________

Periodic Payment: $________________

Number of monthly instalments: __________

Payment start date: _________________

Overdue accounts can sometimes attract an interest payment.

The duration of orthodontic treatment varies in each individual case however, it usually takes 12 to 24 months to correct the orthodontic problem. Subsequently, the teeth will be retained in their new position for a further 12-24 months using a special removable retaining plate. This estimate of treatment is based upon previous professional experience and assumes complete patient cooperation.

Please note that lack of patient cooperation in the form of missed appointments, unwarranted breakages and failure to wear elastics as directed can extend treatment time.

If you have any queries or problems you would like to discuss regarding the treatment or financial arrangements, please do not hesitate to contact the office.

Thank you for your attention and cooperation.

Responsible Party Signature: ______________________ **Date:** __________________