THIS IS A SAMPLE FORM AND NOT INTENDED AS LEGAL ADVICE.
YOU SHOULD ALWAYS HAVE A LOCAL ATTORNEY REVIEW LEGAL DOCUMENTS.

PATIENT CONTRACT

PATIENT NAME: _____

RESPONSIBLE PARTY(IES): _____

RESPONSIBLE PARTY'S ADDRESS: _____

_____

RESPONSIBLE PARTY'S TELEPHONE #: _____

DESCRIPTION OF TREATMENT: _____

_____

ESTIMATED TREATMENT TIME: _____ YEARS _____ MONTHS

_____ ("Orthodontist") agrees to provide the orthodontic services described above, and in consideration, I/we agree to pay the following fee according to the terms indicated:

TOTAL TREATMENT FEE: $_____

AMOUNT DUE PRIOR TO BRACES APPOINTMENT: $_____

LESS: ESTIMATED INSURANCE PAYMENT $_____

ESTIMATED AMOUNT I/WE PAY: $_____

MONTHLY INSTALLMENT: $_____

LESS: ESTIMATED INSURANCE PAYMENT $_____

ESTIMATED AMOUNT I/WE PAY: $_____

NUMBER OF MONTHLY INSTALLMENTS: _____

DUE DATE OF EACH MONTHLY INSTALLMENT: _____

Amounts paid by my/our insurance, if any, will be deducted from the amounts I/we pay as shown above; however, I/we are responsible for any amounts not paid by my/our insurance. The total fee does not include the cost of retainers, office visits during the retention phase of treatment, or records

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duplication charges if I/we request copies of records. If I/we choose not to proceed with treatment, I/we will pay the cost of initial records and models.

I/we also agree, on our behalf or on behalf of the patient, as the case may be, to follow all instructions provided by Orthodontist as to hygiene, diet, etc., to promptly keep each appointment as scheduled, and to refrain from activities resulting in excessive appliance breakage. Failure to do so may result in additional treatment time and charges.

I/we understand that if I/we fail to make any payment due, declare voluntary or involuntary bankruptcy, or fail to cooperate with treatment, Orthodontist may immediately discontinue treatment and terminate this Contract. In such case, I/we will pay all amounts attributable to treatment rendered up to that time, costs associated with removal of braces or other appliances, and any costs of collection, including attorneys' fees and interest on overdue amounts at the rate of 18% per annum. I/we hereby consent to the sharing of any and all patient and account information with any person who signs this form.

ORTHODONTIST:

By:_____
Date:_____

RESPONSIBLE PARTY(IES):

_____
Date:_____

_____
Date:_____