ELITE
ORTHODONTICS

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1st STAGE ORTHODONTIC TREATMENT FINANCIAL AGREEMENT

Disclosure statement and agreement for the professional services in compliance with regulation Z of the Federal Truth in Lending Act:

Patient _____ D.O.B. _____

Responsible Party _____

Treatment covered by this agreement: _____

_____

_____

1. Professional Fee (Metal)	$ _____
_____	$ _____
_____	$ _____
2. Total Treatment Fee	$ _____
3. Less Estimated* Insurance	$ _____
4. Estimated Responsible Party Portion	$ _____
5. Less Initial Payment (Due $)	$ _____
6. Unpaid Balance	$ _____

This Agreement covers a **1st Stage Orthodontic Treatment** phase only. I understand that a **2nd Stage Orthodontic Treatment (Braces)** will be needed after all permanent teeth have erupted and that when braces are needed, the additional services and additional fee will need to be determined at the time.

_____ (Initial) **I understand that this amount is an estimate only and that I am personally responsible for any balance not paid by the insurance.*

_____ (Initial) *Due to our flexible financing, in the event orthodontic services are terminated for any reason before the completion of treatment, I will be responsible for a minimum of one-third of the total treatment fee AND the remaining balance which will be prorated depending on each patient's individual estimated treatment time.*

_____ (Initial) *This fee is based on current treatment costs and will be valid for a period of 90 days. This treatment fee includes all office visits while in active treatment with braces, initial retainers, and follow-up retainer checks for 12 months after the braces are removed. This fee does not include professional services rendered by the other offices.*

_____ (Initial) *The account must be paid in full by the end of orthodontic treatment.*

_____ (Initial) *This financial arrangement is made for your convenience in making payments. The amount per month does not reflect the number of visits and is constant. There may be multiple visits or no appointments at all during a calendar month.*

_____ (Initial) *I authorize payment directly to Dr. Nader Ehsani of any insurance benefits otherwise payable to me.*

_____ (Initial) *I understand that where appropriate, credit bureau reports may be obtained.*

Unpaid Balance (#6 above) is payable to Dr. Nader Ehsani in _____ monthly installment of $ _____each, and one installment of the remaining balance. The first Installment is payable on and subsequent installments on the same day of each consecutive month until paid in full.

(Continued on reverse side)

Additional Charges:

1. I understand that a $10.00 late fee will be charged on all payments which are ten days past due. There will be a $25.00 charge for any returned checks.

2. Excessive damage to the brackets or bands: We allow for the possibility of 3 brackets or bands becoming loose during treatment. After that, there will be a charge of $35.00 for each loose bracket or band.

3. Excessive failed or canceled appointments. We ask that you let us know 24 hours in advance if an appointment has to be rescheduled. We allow for the possibility of 3 failed appointments or appointments canceled without the 24 hour notice before any charges will be assessed. After that, there will be a charge of $25.00 for each appointment failed or canceled without the 24 hour notice.

4. Lost or broken appliances (retainers, biteplanes, functional appliances, Invisalign® aligners, headgears, mouthguards): These charges will vary depending on the appliance and the damage incurred.

5. Treatment may sometimes take longer due to circumstances beyond the control of the patient or the doctor. In that event, the original treatment fee will be honored. However, if treatment is extended due to the patient's failure to follow instructions or keep scheduled appointments, a fee of $120.00 per visit will be charged until treatment is completed.

6. In the event that the account has to be turned over for collection, the undersigned shall also be responsible for all costs of collection, including reasonable legal fees, court costs, accrued interest and all other costs of collection.

_____ *(Initial)* **Retention of Documents Relating to Your Care and Agreement.** By signing this, you understand and agree that it is our policy to scan original documents and store the documents in an electronic form. Further, you agree that any agreement bearing a scanned signature, which is printed from the electronic form, has the same force and effect as the original document.

I HEREBY CERTIFY that I have read, understand and agree to the terms outlined in this agreement.
I have also received a copy of this agreement the _____ day of _____

Signed _____ Relationship to the patient _____

Guarantor _____ Date _____

Witness _____ Date _____