# Orthodontic Treatment Plan - Immediate Family

Patient Name: _____ Date: _____

Summary of Treatment Plan:

- Full Upper and Lower Braces
- Records and Retainers Included
- Estimated Length of Treatment Time: _____ months
- Appliances Needed (Y/N): _____

| | |
|---|---|
| Comprehensive Treatment (Silver): | $1000 |
| Clear Upgrade (if applicable) | $250 |
| Total Treatment Cost: | $1000(**metal**) / $1250(**clear**) |
| Insurance Estimate: | $_____ |
| Total Patient Cost: | $_____ |

## Payment Options:

☐ **Discount Route:** Pre-pay in full for your treatment and save 5%. Total due today: $N/A

☐ **Payment Plan:** Pay your downpayment today followed by _____ automatic monthly payments of $_____ starting next month (1st or 15th) Total due today: $_____

After our employee's 90 days are met, a special discount is available for employees and immediate family members! If the employee **leaves or is terminated before treatment is completed, I understand that the full fee of $4,500 will be due and any payment made during employment will be applied to the updated treatment fee.**

Permanent retainers can be purchased at the end of treatment. Permanent retainers are not included in this treatment plan.

Should I choose to accept this treatment, I understand that the total fee is my responsibility and that the insurance is billed as a courtesy to assist me in paying my obligation. I acknowledge the insurance responsibility shown above is only an estimation and NOT a guarantee of payment. If the insurance pays differently, I will either receive a refund or be responsible for the difference and have my credit card on file charged for the amount owed or have my payment plan extended; whatever the practice deems best. I acknowledge that the fees estimated are based on my treatment plan as listed above and my treatment plan may change, altering the total cost of care. I further understand that my balance must be paid in full before the removal of my braces or Invisalign.

As teeth naturally shift and change over time, we cannot assure our original treatment plan will remain the same in the future. Therefore, we guarantee our treatment plan and terms for 30 days from the original consultation date. We are grateful for the time you shared with us and hope we provided a superb experience at Thrive Dental and Orthodontics!

Patient/Parent Signature:_____ Date: _____