Orthodontic Treatment Plan - Braces

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	$_____**(metal)** / $_____ **(clear)**
Insurance Estimate:	$_____
Total Patient Cost:	$_____**(metal)** / $_____ **(clear)**

Payment Options:

☐ **Discount Route:** Pre-pay in full for your treatment and save 5%. Total due today: $ _____(m)/_____(c)

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

Start your orthodontic treatment within 10 days of your initial consultation and receive *$500 toward general dental treatment.**

*This dental credit may be applied to dental copays for patients with PPO insurance. Patients without general dental insurance will receive a copay match of up to $500.

I understand that the amount due is my responsibility should I choose to accept this treatment and that insurance is billed as a courtesy to assist me in paying my obligation. I understand that insurance responsibility shown above is only an estimation and NOT a guarantee of payment by my insurance. If the insurance company pays more, I will receive a refund. If the insurance company pays less, I will either receive a bill for the difference, have my credit card on file charged for the amount owed, or have my payment plan extended; whatever the dental practice deems best. I understand that if my insurance company fails to pay within 60 days of the claim being submitted, the full amount due is my responsibility and I will make payment in full. I understand that the fees estimated are based on my treatment plan as listed above. The treatment plan may change, altering the total cost of care. I understand that I may be charged for broken brackets or poor compliance. *I further understand that my balance must be paid in full before the removal of my braces or clear aligners*.

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: _____