Brick Pediatric Dentistry

& Orthodontics, P.C.

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ORTHODONIC TREATMENT CONTRACT

Date: ____________

Account Number: ____________

PATIENT INFORMATION

Patient: ____ Date: ___________________

Responsible Party Name: ____

Responsible Party Address: ____

Responsible Party Home #: ______________________ Responsible Party Cell #: ______________________

Responsible Party Business #: ______________________ Relationship to Patient: ______________________

CONTRACT OF FEES

FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES RENDERED

1. Orthodontic Treatment Fee (**excludes** workup) $__________________________
2. Less Deposit (Due ___________) $__________________________
3. Unpaid Balance $__________________________

Responsible party agrees to pay "**Unpaid Balance**" (#3 above) to "Brick Pediatric Dentistry & Orthodontics" in ______ monthly installments of $_________ each. The first installment is payable on _________ and subsequent installments on the same day of each consecutive month until paid in full. Late fees on past due accounts will be assessed. If treatment is extended due to lack of patient cooperation, missed appointments, or traumatic injury, we reserve the right to charge additional fees.

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. A LATE FEE OF 1.5% MONTHLY WILL APPLY ON OVERDUE ACCOUNTS. I WILL BE RESPONSIBLE FOR ANY COSTS INCURRED BY THIS OFFICE TO COLLECT OVERDUE ACCOUNTS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY CERTIFY THAT I HAVE READ & RECEIVED A COPY OF THE AFOREGOING DISCLOSURE STATEMENT.

PRINT NAME ______________________ SIGNATURE ______________________ DATE ____________