CENTENNIAL HILLS
orthodontics

Consent Terms for: (Patient Name)_____

Initial **Financial Agreement**

- _____ **Payment is expected at the time services are rendered,** unless other arrangements have been made.
- _____ Accounts more than 60 days past due will be addressed prior to continuation of active treatment.
- _____ Additional charges apply for **missed appointments** not canceled at lease 24 hours prior.
- _____ Additional charges will be added for frequently **broken appliances** and are based on the appliance type, nature, and frequency of the damage, beginning after the *second* broken bracket and *first* re-cemented appliance. This is handled on a case-by-case basis.
- _____ All **outstanding balances** must be paid in full prior to the removal of orthodontic appliances.
- _____ At the end of the original contact length (generally 18-24 months), additional charges may be incurred if there has been a **failure to comply with orthodontic treatment recommendations.** Such failures include, but are not limited to: lack of elastic band wear (rubber bands), missed appointments, extended lapses in office visits, frequently broken appliances, changes in treatment plan, etc.
- _____ In general, "additional charges" are not covered by insurance benefit providers
- _____ We require every patient's SSN in order to ensure payment for our services. If you are not willing to provide us with your SSN you have the option of paying for your services up front at the time of your visit. You will be reimbursed if we receive payment from your insurance company.
- _____ As a courtesy, your **benefit provider will be billed three times for services rendered**. Should an insurance company fail to pay its portion of the benefit in full, the remaining balance (or collection thereof from the insurance company) becomes **your responsibility**.
- _____ Changes to the estimated benefit during treatment will result in the full remaining balance reverting to the undersigned. Such shall be payable over the months remaining on the original contract. It is **your responsibility** to provide updated benefit information to our office when changes in coverage occur.
- _____ In cases of divorce, the undersigned will be responsible for the entire treatment balance. Centennial Hills Orthodontics will not mediate payment disputes between parties.
- _____ A **returned check** for any reason will necessitate all future payments to be made in cash or certified funds from that point on. A $35 fee will apply for all returned checks.
- _____ If payment is not made in accordance with these terms and conditions the signer of this document will be liable for all collection costs.
- _____ Centennial Hills Orthodontics does not send financial statements or invoices via mail services, but provides paperless billing through our website (www.centennialhillsortho.com > Patient Login).
- _____ Centennial Hills Orthodontics provides email and text message reminders for upcoming appointments; phone call reminders are provided for initial and final appointments due to the length of time required in the chair with the doctor. I understand that I must provide a current email address to be put on file and if text message reminders is desired, I must then log into my account (www.centennialhillsortho.com > Patient Login) to sign up and approve text message reminders.
- _____ I hereby provide permission to Centennial Hills Orthodontics to email upon request receipts of payments or invoice to my email: *(please provide current email address)*

Email:_____

Signature: _____Date: ____ / ____ /____

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CONSENT OF RECORDS AND RELEASE OF PATIENT INFORMATION

- I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment, and to the above doctor(s) and, where appropriate, staff providing orthodontic treatment prescribed by the above doctor(s) for the above individual. I fully understand all of the risks associated with the treatment.
- Your protected health information (name, date, address, orthodontic diagnosis and treatment plan, etc.) may be shared in connection with your treatment with health care providers and insurance benefit providers. Under the US Dept. of Health and Human Services privacy regulations, this office must obtain consent to do so. There is a complete privacy policy on file for your review if requested. I understand that once released, the above doctor(s) and staff has (have) no responsibility for any further release by the individual receiving this information.

CONSENT TO THE USE OF RECORDS

- I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment and retention for purposes of professional consultations, research, education, or publication in professional journals.
- I hereby give Centennial Hills Orthodontics permission for the use of my/my child's name and image(s) in the use of social media communications/contests.

- ____ Please Initial If you wish to **decline the use of records.**

ACKNOWLEDGEMENT

- _____ I hereby acknowledge that I have read and fully understand the AAO consent form. I also understand that actual results may differ from the anticipated results, based upon the patient's clinical condition.
- _____ I hereby consent to the treatment proposed and authorize the orthodontist(s) indicated below to provide the treatment.
- _____ I understand that my treatment fee covers only treatment provided by the orthodontist(s), and that treatment provided by other dental or medical professionals is not included in the fee for my orthodontia treatment.

I have read the Orthodontic Treatment, Financial and Health Terms and have clarified any questions I had regarding these policies provided by Centennial Hills Orthodontics. I do hereby agree to the aforementioned terms.

Signature of Patient or Responsible Party _____

Printed Name _____ Date _____ / _____ / _____

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