JEFF THOMPSON ORTHODONTICS

PAYMENT SCHEDULE & CONTRACT

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Patient/Parent Name_____

Address_____

City_____State_____Zip_____

Re:_____

Orthodontic Records, Diagnostic Evaluation and Consultation	$_____
Orthodontic treatment Fee	$_____
Anticipated Insurance Adjustment	$_____
Anticipated Insurance Payment	$_____
Ceramic or Gold Brackets	$_____
iBrace Lab Fee	$_____
Paid in Full Reduction	$_____
Less Initial Payment	$_____
Unpaid Balance of Fee	$_____
Finance Charge	$_____none_____

Patient hereby agrees to pay the unpaid balance of fee_____

to be payed in equal installments of_____.

The first installment being payable on_____.

All subsequent installments paid _____ as agreed upon.

**If insurance benefits are denied or revoked, the patient/parent will be responsible for any unpaid balance.*
**If account becomes more than 30 days delinquent, a $15 fee will be assessed per month.*
**Accounts that become 60 days past due will be placed on non-progressive status, where only maintenance and emergency appointments will be scheduled.*

I hereby certify that I have read and agree with the foregoing statement.

_____ _____
Signature of patient or parent, if patient is a minor. Date

We only offer payment schedules as a contracted arrangement with payments spread over the length of your anticipated active treatment time.
Note: This agreement is submitted in good faith to comply with the disclosure requirement, Law 12CFRZZ6 Regulation Z, truth in Lending, showing no interest or finance charge is being made. We thank you for your cooperation.