GALLIGAN FAMILY DENTISTRY

CARING FOR EVERY SMILE, EVERY GENERATION

Orthodontics Financial Options and Policies

This special agreement is for orthodontic treatment and replaces our standard financial options & policies

Treatment Fees

Invisalign Aligners	Lite	**$4700**	□
	Standard / Teen	**$5900**	□
Adjunct Orthodontics	Appliance in Conjunction w/other Ortho	**$300**	□

* Initial set of retainers and X-ray/Photo Records are ***included*** with all treatment modalities - no additional fees! *

Orthodontic Financial Options

1. 6 or 12 Month No-Interest In-House Financing – Recurring Credit Card Drafts

- Standard/Teen Invisalign - 12 months equal monthly payments
- Invisalign Lite, Phase I Treatment – 6 months equal monthly payments
- Your credit card will be securely kept on file and charges processed monthly

2. 5% Pre-Payment Account Reduction – Cash or Check

- For pre-payment of full treatment fee
- Payment to be made at or prior to the start of treatment
- Insurance filing and management is to be performed by the patient for this financial option

3. 5% Immediate Family/Sibling Account Reduction

- Fee reduction applies to all subsequent family members beyond initial full-fee family member
- Fee reduction applies to the initial treatment fee amount if less than the subsequent family member fee

Orthodontic Financial Policies

1. Payment Sequence

If the No-Interest In-House Financing option is selected, then equal, no-interest payments of the total orthodontics fee are required each month beginning at the Records appointment and each subsequent month.

Full payments including 5% Accounting Reduction payment to be made at the Records appointment.

Payment in full is required prior to the completion of treatment.

2. Fees Inclusion

Stated fees include all records, routine treatment appointments, and initial set of retainers. Routine appointments do not include additional appointments required due to poor compliance or loss/breakage/replacement of retainers. Additional appointment and/or materials fees will be required for the aforementioned circumstances.

3. **Critical Dental Treatment**

   Critical dental treatment to stabilize oral diseases must be performed prior to initiation of orthodontic treatment. Treatment will be discussed in detail if relevant to your oral condition.

4. **Appointment Reservations**

   Your appointment and treatment room is reserved specifically for you**.** Therefore, we require a cancellation or rescheduling notice of **24 business hours** to ensure that our treatment room is fully utilized and appointment change requests to other patients is minimized. **Our business hours are Monday – Thursday, 8:30 a.m. to 5:00 p.m**. Appointments cancelled or rescheduled without 24 business hours notice will be subject to a $50 cancellation/rescheduling fee.

5. **Insurance Filing**

   We file insurance as a courtesy, except when Pre-Payment Accounting Reduction financial option is chosen. If we file insurance on your behalf, we will make every effort to help you utilize your benefits. However, dental insurance is a contract between your employer, and the insurance company and patients are ultimately responsible for payment of dental treatment. Patients will be responsible for insurance payments, if applicable, that are not received within 90 days of the agreed upon terms by your insurance company.

6. **Treatment Warranty and Guarantee**

   Although every effort will be made to reach all or most treatment goals, no warranty or guarantee is implied for orthodontic treatment.

7. **Breach of Financial Options and Policy Agreement**

   Failure to comply with this financial agreement may result in discontinuation or termination of orthodontic treatment until an account is reconciled.

Please file this agreement for future reference. If you should have questions regarding your account or if you would like a report of your account status, please inform one of our staff who will be happy to assist you.

I understand and agree to the aforementioned Orthodontic Financial Options and Policies and realize that this information is intended only for my orthodontic treatment:

_____	_____	_____
Name	**Signature**	**Date**