General Consent and Practice Policy

The doctors and staff at this practice are committed to our patient's superior oral health. We follow scientific and ethical principles in order to provide our patients with the highest standard of orthodontic care. We try to create a fun, friendly and comfortable environment and we work hard to keep overall treatment length and appointment times to an absolute minimum. We know you have a choice in orthodontic providers and we hope that these goals are the primary reasons you have chosen our practice. The following practice policies help reinforce these guiding principles.

_____ **Payment/Insurance Policy:** Unless other payment options are arranged through a signed contract with the office, payment in full is due at the time of service. We accept all major credit cards, cash, or personal checks. We cannot guarantee any estimated coverage when billing insurance. Patients are responsible for determining if their insurance is contracted for the services that will be provided. Patients are responsible for any remaining balance not paid by insurance. There will be a $50 service fee on any returned checks. All unpaid balances are subject to a 10% processing fee and may incur a 1.5% monthly finance charge. All delinquent balances must be paid prior to incurring any new charges. Any service overpaid will automatically be refunded to the patient's original payment method within 60 days. Checks will be issued within 60 days from the payment date for patients who made a cash payment.

_____ **Missed or Canceled Appointment Policy:** Due to the busy nature of our practice and as a courtesy to the doctors and staff who are providing care, we ask that you please make your appointments a top priority. If you are unable to make the scheduled appointment, please give us sufficient notice to be able to fill the appointment slot. We ask that you call to reschedule or cancel at least 24 hours in advance. If you miss or break your appointment with less than 24 hours notice, you may be subject to a cancellation fee up to $100. A second last minute cancellation or no-show may lead to the end of the doctor-patient relationship.

_____ **Late Appointment Policy:** We ask that patients be on time for all scheduled appointments in order to fully utilize their appointment time and minimize the impact to other patients scheduled that day. If a patient is more than 10 minutes late to an appointment they may be required to reschedule or asked to wait until after the on-time patients have been seen. Regular tardiness may lead to the end of the doctor-patient relationship.

_____ **Consent to Treat Policy:** I give permission for the practice to perform orthodontic procedures within the scope of dentistry as deemed necessary. I acknowledge that every orthodontic case is unique and understand that occasional adjustments to the original treatment plan may be necessary to achieve the best result. I authorize the provider to use their professional judgment for procedures in addition to or different from those originally contemplated. I have provided as accurate and complete medical history as possible including those antibiotics, drugs, medications, and foods to which my child is allergic.

I give my permission to the following individuals to bring in my child/children to the practice for their appointments that may include any and all dental procedures.

_____ **Communication Policy:** Our top priority is to give you all the information needed to make informed decisions in regards to your/your child's oral health. This includes providing you with recommended procedures, the risks of those procedures, any treatment alternatives, and an estimate of the costs involved to perform those procedures. If you have any concerns about our treatment or policies, please bring them immediately to our attention so that we can resolve any questions and continue to develop a long-term relationship where your/your child's oral health and dental experience is number one for both of us.

_____ **Communication from Bluetree Brands:** I give my consent to receive relevant communication from Bluetree brands (parent company) and its affiliated partners.

_____ **Social Media/Image Consent:** I give consent to use images taken of me/my child to showcase the extraordinary care we have received.

_____ _____

Parent/Guardian's Signature Date

_____ _____

Printed Name Relationship to Patient

_____ _____

Patient/Parent Name Date

_____

Signature