

ALIGN ORTHODONTICS & TMJ TREATMENT CENTER

Creating healthy, beautiful & confident smiles

Align Orthodontics Financial Policy & Patient Agreement

Contract

Insurance Benefits are contracted between you and your insurance company, NOT Align Orthodontics and your insurance company. **Insurance companies do not guarantee benefits they quote.**

Our Policy

Align Orthodontics will submit claims on your behalf on the date you received service and allow your insurance company **upto 90 days** to pay your claim. Our treatment plans are an **estimate only and will be valid for 90 days**. After that, any new findings may need to be examined and diagnosed for proper treatment at which time any current fees may apply.

Broken Appointment Policy

Confirming appointments is done as a courtesy to our patients. There will be a \$25.00 fee per-patient, if an appointment is broken. An appointment is considered broken for any of the following: failure to show up for a scheduled appointment, canceling or rescheduling without giving at least 48hr. notice, or showing up more than 15 min late.

The following payment methods are accepted for your convenience:

Cash Visa/MC American Express Care Credit/ Chase Health/ Citi Health

Patient Responsibility

- (1) Pay **estimated** portion at each date of service (including ALL co-pays, deductibles, and non-covered procedures), at the time treatment is provided.
- (2) **Notify** Align Orthodontics when a change has occurred in your benefits.
- (3) **Pay monthly payments according to financial contract.**

Release of Personal Information

I authorize the release of information concerning my (or my child's) healthcare to this additional person or organization:

Understanding and Agreement

I understand and agree to the terms of this agreement above, including paying the difference between quoted and actual benefits. I will pay my **estimated portion** of the charges at each date of service/ according to financial contract and will **notify Align Orthodontics** if a change has occurred in my benefits. Finally, **I agree to pay any unpaid balance remaining after insurance payment and/or remaining 90 days** from the date I received the service. I also understand that Align Orthodontics reserves the right to apply a late payment charge of \$15 for past due monthly payments.

Patient Name: _____

Responsible Party Signature: _____

Date: _____