Clear Aligner Payment Options

Patient Name: ____________________________________ Date: ____________________________________

Doctor Name: ____________________________________ Total treatment: ___________________________

Accept	**Decline**	**Select from these payment options**:
		Total payment in full for treatment
		1/2 – 1/2 (Credit Card on file) 1/2 of total fee today Remaining of ½ of total fee at Orthosnap Delivery
		1/3-1/3-1/3- (Credit Card on file) 1/3 of total fee today 1/3 automatic payment on ____________________ 1/3 automatic payment on ____________________
		Custom Payment Plan $_______ of total fee today automatic payment on ____________________ automatic payment on ____________________
		Financing Options (*Pending application and approval) _____ Care Credit or Cherry _____ Healthcare Finance Direct

Treatment Itemization:

Orthosnap Treatment: $_____________

Retainers: $_____________ (1 set @ $__.00)

Estimated Ortho Benefits: $_____________

Estimated Dental Benefits: $_____________ (Exam, Photos, Scans, X-ray, Diagnostic Casts, Case Presentation)

Orthosnap Promotional Discount: $_____________

Friends & Family Referral Promotion: $_____________

Case Set Up Deposit: $ _____ (*Non-refundable. Will be deducted at start of treatment.)

Additional Services: ______ 4 Sets of Retainers $_____________

______ Whitening $_____________

Treatment Down Payment: $_____________

TOTAL PATIENT INVESTMENT: $_____________

IMPORTANT: This ORTHOSNAP FINANCIAL PLAN IS ONLY VALID UNTIL 6/30/202_ ONLY. “Treatment” defines active tooth movement. “Retention” defines inactive movement and final tooth position. Once in retention, the case is no longer active. If retainers are lost or you do not comply with wearing your retainers as prescribe by the doctor, there are additional fees that will apply. Ortho and Dental Benefits are an estimated amount. Payment may vary based upon the deductible and plan limitations. This is to certify the above treatment fees and payment options have been explained to me, and I fully understand and accept the nature of the treatment recommended. I agree to pay reasonable attorney fees, court costs and collection costs incurred by the Dentist in collection and enforcement of the debt.

Patient Signature: ______________________________________ Date: ___________________________