## *Orthodontic Treatment Payment Agreement*

Thank you for choosing **Dr. Bales and his team** for your orthodontic treatment. The following agreement outlines the payment terms. Please keep a copy for your records.

Date: _____

Name: _____

Address: _____

I/We, _____, agree to pay Dr. Jeffrey Bales Dental Corporation for Orthodontic

Treatment for _____in the following manner:

***Payment Option 1.***

Full Payment $_____ on the day the upper braces are placed

***Payment Option 2.***

Initial Payment $_____ on the day the upper braces are placed

and Monthly payments of $_____for _____ months

***Monthly payments must be made with pre-authorized payments (1st, 7th, 15th or 21st) or credit card left on file.***

**We must have the signature of both parents. If only one parent/guardian is responsible for payment, then only one signature is required.**

Accepted and Agreed:

_____ _____
**Signature of Patient Or Parent** **Date**

_____ _____
**Signature of Patient Or Parent** **Date**

_____ _____
**Treatment Coordinator** **Date**

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