



Orthodontic Treatment Payment Options

We are proud to have an inclusive fee without hidden charges. Interceptive treatment fees include placement of appliances and all associated appointments. Full treatment fees include placement of appliances and all associated adjustment appointments, removal of appliances, one set of retainers and one year of follow-up visits.

Option #1- In-House Financing

This option requires a minimum down payment PRIOR to the placement of the orthodontic appliances, with the remaining balance paid in monthly installments over the course of treatment. Accounts must be paid in full before the end of treatment. The payment date will be monthly according to the date appliances are placed. For example, if appliances are placed on the 2nd day of the month, subsequent payments will be due on the 2nd of each month. Please fill out and sign the attached form and bring it to the banding appointment if you would like for us to automatically withdrawal your payments from a credit card.

*Patients utilizing flexible spending accounts may make special payment arrangements if necessary.

Option # 2 – Payment in Full

Patients opting to pay the account in full when treatment begins and contract is signed will receive a 3% courtesy on the total case fee when paid for by cash, check or credit card.

- Please note that treatment times differ from patient to patient. Payment options do not correspond to the estimated treatment time but are provided for your convenience. Additional charges will apply for lost or broken appliances.

Please contact our office if you have any questions about these options.

We gladly accept Visa and MasterCard



Auto Payment Authorization

Patient Name _____ Patient # _____

Responsible Party Name _____ SS# _____

Credit Card

Credit Card Account# _____ Credit Card: VISA MASTERCARD

Expiration Date _____ Verification #(3 digit code on back of card) _____

Cardholder's Name _____

Draft Date- Debited monthly on the contractual due date _____

Authorized Signature _____

All account changes must be submitted in writing and signed by the above party within 7 days of draft date.

I authorize Roy Orthodontics to automatically debit the above account until the entire contracted balance is paid in full. I further agree that in the event that funds are not available in above account or if charges are denied, a fee of \$50 will be charged by Roy Orthodontics.

Office Use Only

Total withdrawal \$ _____ Monthly Payment Amount \$ _____

Final Payment amount \$ _____ Total Number of Monthly Withdrawals _____

Questions to Ask your Insurance Company to Verify Coverage

If you are unaware of your Orthodontic Insurance benefit, please call the number on the back of your insurance card or the personal department of your employer and ask the following questions.

1. Does our dental coverage include orthodontics?
2. What are our benefits? (Normally companies pay at a 50% rate up to a lifetime max of @ \$1000)
3. Is there an age limit on the coverage?
4. Is there a waiting period before coverage begins?
5. How are the benefits paid?
6. What is the mailing address for dental claims?

Things to know about your Insurance coverage:

1. Insurance coverage is a contractual agreement between a patient and the patient's insurance company, not Roy Orthodontics.
2. Roy Orthodontics is happy to file claims on behalf of the patient, however it is the patient's responsibility to monitor the details of the coverage and claim status with the insurance company.
3. It is customary for insurance companies to pay out orthodontic benefits on a monthly or quarterly basis; rarely do they pay in a lump sum. This means that if a policyholder's employment changes or a policy terms prior to the completion of treatment, any remaining insurance balance will become the patient's responsibility.
4. Any information obtained from your insurance company by an employee of Roy Orthodontics is not a guarantee of payment. If for any reason an insurance company pays less than the estimated benefit, the patient will be responsible for the remaining portion.
5. It is the patient's responsibility to provide Roy Orthodontics with any changes in insurance coverage within 10 working days of said change

Dental Insurance Information

*This form is for DENTAL coverage only. The information you provide will be used to verify your orthodontic benefit, so **please fill out this form completely**. As a courtesy, we are happy to file an insurance claim on your behalf once active treatment is initiated.
Without this information we are unable to file your claim.*

Current Date: _____

Patient Name: _____
Last First (Nickname)

Patient's DOB: _____ Patient's SSN: _____

******Optima is for medical coverage only. Please provide dental carrier info.******

Primary Insurance

Primary Subscriber's Full Name: _____
Last First (Nickname)

Subscriber's relationship to patient: (circle one) Self/Parent/Step-parent/Grandparent/Other _____

Subscriber's DOB: _____ Subscriber's SSN: _____

Subscriber's Home Address: _____ City _____ State _____ Zip _____
(If different than patient)

Subscriber's Best Daytime Contact #: _____ (Home, Work, Cellular, Other _____)

Insurance Carrier Name: _____ Phone # _____

Ins. Company. Address: _____ City _____ State _____ Zip _____

Subscriber ID #: _____ Group #: _____

Company Insured Works For: _____

2nd Insurance (If Applicable)

Primary Subscriber's Full Name: _____
Last First (Nickname)

Subscriber's relationship to patient: (circle one) Self/Parent/Step-parent/Grandparent/Other _____

Subscriber's DOB: _____ Subscriber's SSN: _____

Subscriber's Home Address: _____ City _____ State _____ Zip _____
(If different than patient)

Subscriber's Best Daytime Contact #: _____ (Home, Work, Cellular, Other _____)

Insurance Carrier Name: _____ Phone # _____

Ins. Company. Address: _____ City _____ State _____ Zip _____

Subscriber ID #: _____ Group #: _____

Company Insured Works For: _____