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TREATMENT SCHEDULING AGREEMENT

Thank you for choosing Oral Dynamics. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Scheduling Policy, which we require you read and sign prior to any treatment.

You will be given an opportunity to review the schedule with the practice administrator after meeting with the Doctor. We will make every attempt to work with you to find the date that best fits into your schedule. Keep in mind that surgical procedures are only performed on Wednesday and Friday mornings.

A $250 deposit is required to schedule your appointment. This payment is non-refundable and covers the administrative costs of scheduling. It is, however, considered a part of your overall fee and is not an additional expense. The $250 deposit is good for three (3) months from the day it is paid. An additional deposit will be required when scheduling additional future treatment.

The balance of your total treatment fee is due two (2) weeks prior to the date of service. If a payment arrangement has been agreed upon, then the initial payment will be due two (2) weeks prior to the date of service. Balances and deposits are payable by cash, check, Visa, Mastercard, or Discover. We DO NOT accept Third Party Financing for deposits or rescheduling fees. If payment is not received your appointment will be removed from the schedule.

SHOULD YOU RESCHEDULE YOUR APPOINTMENT:

-Less than ten (10) business days: Forfeit the $250 deposit, incur $250 rescheduling fee.
-Less than three (3) business days: Forfeit the $250 deposit, incur $500 rescheduling fee.
-Within one (1) business day: Forfeit the $250 deposit, forfeit your down payment, and incur $500 rescheduling fee.
-Should you reschedule more than two (2) times (for a total of 3 dates): The total fee for treatment will be held as a deposit, not a down payment, for your date of service and will be forfeited should you cancel your appointment at any time.

I acknowledge that I have read and understand the above treatment and agree to comply with Oral Dynamics treatment scheduling agreement. I understand that Oral Dynamics has full discretion to enforce the above policies. I understand by signing below I am not obligated to schedule treatment, but am aware that should I schedule, the deposit will be required.

Patient/Guardian Signature Date Print Name

Treatment Coordinator Signature Date Print Name