



SIX MONTH SMILE FINANCIAL AGREEMENT

(filled out at records appt.)

The fee for your Short Term Orthodontic treatment is \$_____

Payment in Full with 5% courtesy (Cash, Check) \$_____

\$1750.00 at records appointment and \$ 291.67 at each visit. (Cash, Check, CC)

Financing through Care Credit (must qualify)

\$_____

I hereby agree to the terms of this agreement. I understand the financial decision I have made and I commit to make the appropriate payments. If I have chosen to make payments at each visit, I agree to pay the appropriate amount at the time of each visit.

Signed: X _____ Date: X _____

List Treatments and Collected Payments Below:
