DISCONTINUATION OF TREATMENT

I _____, hereby acknowledge that AR Dentistry and Braces is discontinuing orthodontic treatment of (myself) (my child) due to non-payment, non-compliance, or at my own request. I understand that as part of discontinuation of treatment all orthodontic appliances and braces will be removed, final photographs and x-rays will be taken for records, and no retainer(s) will be issued.

I further acknowledge that ending treatment early may negatively impact the effectiveness of orthodontic treatment, and that (my) (my child's) orthodontic progress may reverse over time if I do not use a retainer.

I understand that I will not accrue additional expenses as a result of current orthodontic treatment. I acknowledge that I currently owe AR Dentistry and Braces _____for orthodontic treatment and services already received. I also acknowledge that discontinuation of treatment does not affect my obligation to pay for treatment already performed.

_____ Date: _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN

_____ Date: _____

ORTHODONTIST SIGNATURE