DENTISTRY & BRACES

Ben Burris, DDS, MDS • Justin Bethel, DDS

NO-NO LIST

Be careful to protect your orthodontic appliances when you eat. Faithfully follow our instructions below on the “no-no” list of foods to avoid. Remember, every broken bracket could add 6 weeks to your treatment time.

Ice – A thousand times NO! It will totally destroy braces!

Pretzels & Hard Chips- bends wires and knocks off brackets. (Doritos, Tostitos, Fritos)
Hard Rolls & Bagels- Bends wires and knocks off brackets

Ribs, Wings & Bones – Knocks off brackets. Simply remove meat from the bone.

Nuts - No nuts of any kind

Popcorn - The shells lodge between the gum and band.

Raw Carrots, Apples & Celery - Hard as rocks! Chop them up into tiny pieces and chew on back teeth.

Beef Jerky/Slim Jims - Tough as nails!

Pens and Pencils - Favorite exam time food, breaks everything

Candy Suckers, Sweet Tarts & Jolly Ranchers - You might weaken and bite!

Caramel Candy, Taffy & Bubble Gum - Sticky goo which loosens wires & feed the bacteria in your mouth!

Fruit Roll Ups, Frozen Candy Bars, Gob Stopper & Gummy Bears

DENTISTRY & BRACES

Ben Burris, DDS, MDS • Justin Bethel, DDS

WELCOME TO OUR TEAM

Payment Options Worksheet

Treatment Fee with Lifetime Retainers		Treatment Fee without Lifetime Retainers	
Treatment Fee	$ 4795.00	Treatment Fee	$ 3995.00
Less Primary *Estimated* Insurance	$___________	Less Primary *Estimated* Insurance	$___________
Less Secondary *Estimated* Insurance	$___________	Less Secondary *Estimated* Insurance	$___________
Estimated Responsible Party Portion	$___________	*Estimated* Responsible Party Portion	$___________
Less Initial Payment Due	$___________	Less Initial Payment Due	$___________
Total Unpaid Balance	$___________	**Total** Unpaid Balance	$___________

PAYMENT OPTIONS

❑ **Payment in Full with Lifetime Retainers**
A bookkeeping courtesy of 7% which is a savings of $ 335.65 is offered for payment in full at start of treatment, resulting in a one-time payment of $ 4459.35 .

❑ **Payment in Full without Lifetime Retainers**
A bookkeeping courtesy of 7% which is a savings of $ 279.65 is offered for payment in full at start of treatment, resulting in a one time payment of $ 3715.35 .

❑ **Office Payment Plan**
An initial payment of $ 300.00 is due at the start of treatment with the balance being paid in monthly payments of $ 147.80 .

❑ **Flexible Monthly Payment Option- Interest Free (Lending Club or Care Credit)**
- No initial payment
- No interest charges if paid within the specified time period
- 24 Easy Payments of $_______
- Prepayments can be made anytime without penalty

Orthodontic treatment is an excellent investment in an individual's medical and psychological well-being.
Whether you choose Invisalign or braces, we know you will love your new smile!

DENTISTRY
& BRACES

Ben Burris, DDS, MDS • Justin Bethel, DDS

PHOTO AND VIDEO RELEASE FORM

I hereby grant Arkansas Dentistry & Braces absolute and irrevocable rights and unrestricted permission to use photos/videos taken of me or in which I may be included with others, and to use, re-use, publish and re-publish the same in whole or in part, individually or in conjunction with other photos/videos and in conjunction with any media now or hereafter known, and for illustrations, promotions, art, editorials, advertising and trade, or any other purpose whatsoever without restriction.

____
Patient Name

____ ____
Parent, Guardian or Patient (if 18 and over) Date

© 2001, American Association of Orthodontists

DENTISTRY & BRACES

Ben Burris, DDS, MDS • Justin Bethel, DDS

Your Orthodontic Appointments

Patient's Name: ____
First Last

In order to ensure quality orthodontic care, it is imperative that both parents and patients understand the manner in which we schedule your appointments. Our goal is to be the best part of your day. We make it a top priority to value both you and your time. That's why we make every effort to stay on or ahead of schedule. Most parents work and all children attend school. Inconveniencing your work schedule and interrupting your child's studies as infrequently as possible is very important to our entire office. Since the vast majority of our patients are of school age, it is unavoidable that some school-time appointments will be necessary.

In order to be fair to all patients, we alternate appointments during school months. We will be glad to work around certain classes that are very important or ones in which your child may be having problems. We provide your child with school excuses for scheduled orthodontic appointments and it is important for your child to turn these in to the appropriate school official.

We want you to know our staff will work hard to provide the finest orthodontic care in the most convenient scheduling system possible for you and your child. We also have families and children and understand your scheduling concerns and will do everything we can to ensure your child's treatment goes as smoothly as possible.

- LONG APPOINTMENTS, BANDING AND BONDING: These are more detailed and techniquesensitive appointments. Therefore, these appointments will be scheduled during our quieter morning hours.
- EMERGENCIES: (Pain, swelling, or bleeding) This usually results from trauma to the face or mouth. These patients will be seen as soon as possible. Please call our office and we will schedule you accordingly...
- REPAIRS: (Loose bands or brackets, broken arch wires or ties, broken appliances or retainers).These appointments are always scheduled during school hours at a specific time since they are long visits. The vast majority of your appointments over the course of treatment will be short appointments. By seeing our long-visit patients during school hours, it leaves more room in our schedule to see more patients after school hours.
- APPOINTMENTS BROKEN OR NOT CANCELLED WITHIN 48 HOURS: Another appointment will be scheduled but may require waiting 4 to 6 weeks. An appointment during school hours may be arranged sooner.
- DENTAL CHECK-UP: All orthodontic patients must continue to see their regular dentist at least once every 6 months for cleaning.
- Please notify us immediately if your address or phone number changes.

Thank you so very much for understanding!

I have read and agree to the scheduling information above:

Parent signature: ______________________________ Date: ________________

DENTISTRY & BRACES

Ben Burris, DDS, MDS • Justin Bethel, DDS

PRACTICE FINANCIAL POLICIES

PATIENT: ____

FINANCIALLY RESPONSIBLE PERSON: ____

THIS FINANCIAL POLICY is in effect for an Orthodontic treatment that will take APPROXIMATELY_______months. At the end of this time there will be a Retention Phase of treatment that will take one year.

IF TREATMENT IS EXTENDED 3 MONTHS BEYOND ESTIMATED TREATMENT TIME due to lack of cooperation or traumatic injury, there will be an extra charge per month each month until braces are removed. The monthly charge is now 175.00 , but may differ in the future.

IF THERE IS EXCESSIVE BREAKAGE of the braces or loss of removable appliances, retainers, etc., there may be repair or replacement charges to be determined at that time.

IF SERVICES ARE TERMINATED for any reason before the completion of treatment, the account will be adjusted and a just settlement determined, based on the amount of treatment completed.

SERVICES PROVIDED BY OTHERS, Laboratories, etc., outside of this orthodontic practice are not part of the treatment fee.

IF ORTHODONTIC INSURANCE covers all or part of the fee, it may be paid directly to the practice or to the policy holder as arranged. Whatever part of the account balance not paid directly to the practice by an insurance company must be paid by the Financially Responsible Person noted below.

IN THE EVENT THAT A PATIENT TRANSFERS BEFORE TREATMENT IS COMPLETE: Entire fee must be paid in full before removing orthodontic appliances. In the event of a patient transferring before treatment has been completed, 1/3 of the total fee must be met along with a portion of the remaining balance allocated to the number of completed months of treatment at the date of transfer.

____ ______________________

FINANCIALLY RESPONSIBLE PERSON DATE

SIGNATURE ON FILE

I hereby consent to the taking of x-rays, photographs and other necessary records before, during and after treatment and to the use of same by this practice for scientific papers and demonstrations.

____ ______________________

RESPONSIBLE PERSON DATE

SIGNATURE ON FILE FOR INSURANCE

I authorize the release to my insurance company or companies any information including the diagnostic records and diagnosis of any treatment required to comply with applicable law and facilitate the billing and reimbursement for the treatment provided.

I understand that my insurance company or companies will pay periodically throughout the course of the treatment time. If my orthodontic insurance is terminated or canceled while the patient is still in active treatment with this office it will be my responsibility to pay the remaining amount that the insurance did not pay.

____ ______________________

SIGNATURE OF PARTY #1 DATE

____ ______________________

SIGNATURE OF PARTY #2 DATE

DENTISTRY & BRACES

Ben Burris, DDS, MDS • Justin Bethel, DDS

INFORMED CONSENT FOR THE ORTHODONTIC PATIENT. RISKS AND LIMITATIONS OF ORTHODONTIC TREATMENT.

Successful orthodontic treatment is a partnership between the orthodontist and the patient. The doctor and staff are dedicated to achieving the best possible result for each patient. As a general rule, informed and cooperative patients can achieve positive orthodontic results. While recognizing the benefits of a beautiful healthy smile, you should also be aware that, as with all healing arts, orthodontic treatment has limitations and potential risks. These are seldom serious enough to indicate that you should not have treatment; however, all patients should seriously consider the option of no orthodontic treatment at all by accepting their present oral condition. Alternatives to orthodontic treatment vary with the individual's specific problem, and prosthetic solutions or limited orthodontic treatment may be considerations. You are encouraged to discuss alternatives with the doctor prior to beginning treatment.

Orthodontics and Dentofacial Orthopedics is a dental specialty that includes the diagnosis, prevention, interception and correction of malocclusion, as well as neuromuscular and skeletal abnormalities of the developing or mature orofacial structures. An orthodontist is a dental specialist who has completed at least two additional years of graduate training in orthodontics at an accredited program after graduation from dental school.

Results of Treatment

Orthodontic treatment usually proceeds as planned, and we intend to do everything possible to achieve the best results for every patient. However, we cannot guarantee that you will be completely satisfied with your results; nor can all complications or consequences be anticipated. The success of treatment depends on your cooperation in keeping appointments, maintaining good oral hygiene, avoiding loose or broken appliances and following the orthodontist's instructions carefully.

Length of Treatment

The length of treatment depends on a number of issues, including the severity of the problem, the patient's growth and the level of patient cooperation. The actual treatment time is usually close to the estimated treatment time, but treatment may be lengthened if, for example, unanticipated growth occurs, if there are habits affecting the dentofacial structure, if periodontal and other dental problems occur, or if patient cooperation is not adequate. Therefore, changes in the original treatment plan may become necessary. If treatment time is extended beyond the original estimate, additional fees may be assessed.

Discomfort

The mouth is very sensitive so you can expect an adjustment period and some discomfort due to the introduction of orthodontic appliances. Nonprescription pain medication can be used during this adjustment period.

Relapse

Completed orthodontic treatment does not guarantee perfectly straight teeth for the rest of your life. Retainers will be required to keep your teeth in their new positions as a result of your orthodontic treatment. You must wear your retainers as instructed or teeth may shift, in addition to other adverse effects. Regular retainer wear is often necessary for several years following orthodontic treatment. However, changes after that time can occur due to natural causes, including habits such as tongue thrusting, mouth breathing, and growth and maturation that continue throughout life. Later in life, most people will see their teeth shift. Minor irregularities, particularly in the lower front teeth, may have to be accepted. Some changes may require additional orthodontic treatment or, in some cases, surgery. Some situations may require nonremovable retainers or other dental appliances made by your family dentist.

Extractions

Some cases will require the removal of deciduous (baby) teeth or permanent teeth. There are additional risks associated with the removal of teeth which you should discuss with your family dentist or oral surgeon prior to the procedure.

Orthognathic Surgery

Some patients have significant skeletal disharmonies which require orthodontic treatment in conjunction with orthognathic (dentofacial) surgery. There are additional risks associated with this surgery which you should discuss with your oral and/or maxillofacial surgeon prior to beginning orthodontic treatment. Please be aware that orthodontic treatment prior to orthognathic surgery often only aligns the teeth within the individual dental arches. Therefore, patients discontinuing orthodontic treatment without completing the planned surgical procedures may have a malocclusion that is worse than when they began treatment!

Decalcification and Dental Caries

Excellent oral hygiene is essential during orthodontic treatment as are regular visits to your family dentist. Inadequate or improper hygiene could result in cavities, discolored teeth, periodontal disease and/or decalcification. These same problems can occur without orthodontic treatment, but the risk is greater to an individual wearing braces or other appliances. These problems may be aggravated if the patient has not had the benefit of fluoridated water or its substitute, or if the patient consumes sweetened beverages or foods.

Root Resorption

The roots of some patients' teeth become shorter (resorption) during orthodontic treatment. It is not known exactly what causes root resorption, nor is it possible to predict which patients will experience it. However, many patients have retained teeth throughout life with severely shortened roots. If resorption is detected during orthodontic treatment, your orthodontist may recommend a pause in treatment or the removal of the appliances prior to the completion of orthodontic treatment.

Nerve Damage

A tooth that has been traumatized by an accident or deep decay may have experienced damage to the nerve of the tooth. Orthodontic tooth movement may, in some cases, aggravate this condition. In some cases, root canal treatment may be necessary. In severe cases, the tooth or teeth may be lost.

Periodontal Disease

Periodontal (gum and bone) disease can develop or worsen during orthodontic treatment due to many factors, but most often due to the lack of adequate oral hygiene. You must have your general dentist, or if indicated, a periodontist monitor your periodontal health during orthodontic treatment every three to six months. If periodontal problems cannot be controlled, orthodontic treatment may have to be discontinued prior to completion.

Injury from Orthodontic Appliances

Activities or foods which could damage, loosen or dislodge orthodontic appliances need to be avoided. Loosened or damaged orthodontic appliances can be inhaled or swallowed or could cause other damage to the patient. You should inform your orthodontist of any unusual symptoms or of any loose or broken appliances as soon as they are noticed. Damage to the enamel of a tooth or to a restoration (crown, bonding, veneer, etc.) is possible when orthodontic appliances are removed. This problem may be more likely when esthetic (clear or tooth colored) appliances have been selected. If damage to a tooth or restoration occurs, restoration of the involved tooth/teeth by your dentist may be necessary.

Headgears

Orthodontic headgears can cause injury to the patient. Injuries can include damage to the face or eyes. In the event of injury or especially an eye injury, however, minor, immediate medical help should be sought. Refrain from wearing headgear in situations where there may be a chance that it could be dislodged or pulled off. Sports activities and games should be avoided when wearing orthodontic headgear.

Temporomandibular (Jaw) Joint Dysfuntion

Problems may occur in the jaw joints, i.e., temporomandibular joints (TMJ), causing pain, headaches or ear problems. Many factors can affect the health of the jaw joints, including past trauma (blows to the head or face), arthritis, hereditary tendency to jaw joint problems, excessive tooth grinding or clenching, poorly balanced bite, and many medical conditions. Jaw joint problems may occur with or without orthodontic treatment. Any jaw joint symptoms, including pain, jaw popping or difficulty opening or closing, should be promptly reported to the orthodontist. Treatment by other medical or dental specialists may be necessary.

Impacted, Ankylosed, Unerupted Teeth

Teeth may become impacted (trapped below the bone or gums), ankylosed (fused to the bone) or just fail to erupt. Oftentimes, these conditions occur for no apparent reason and generally cannot be anticipated. Treatment of these conditions depends on a particular circumstance and the overall importance of the involved tooth, and may require extraction, surgical exposure, surgical transplantation or prosthetic replacement.

Occlusal Adjustment

You can expect minimal imperfections in the way your teeth meet following the end of treatment. An occlusal equilibration procedure may be necessary, which is a grinding method used to fine tune the occlusion. It may also be necessary to remove a small amount of enamel in between the teeth, thereby "flattening" surfaces in order to reduce the possibility of a relapse.

Non-Ideal Results

Due to the wide variation in the size and shape of the teeth, missing teeth, etc., achievement of an ideal result (for example, complete closure of a space) may not be possible. Restorative dental treatment, such as esthetic bonding, crowns or bridges or periodontal therapy, may be indicated. You are encouraged to ask your orthodontist and family dentist about adjunctive care.

Third molars

As third molars (wisdom teeth) develop, your teeth may change alignment. Your dentist and/ or orthodontist should monitor them in order to determine when and if the third molars need to be removed.

Allergies

Occasionally, patients can be allergic to some of the component materials of their orthodontic appliances. This may require a change in treatment plan or discontinuance of treatment prior to completion. Although very uncommon, medical management of dental material allergies may be necessary.

General Health Problems

General health problems such as bone, blood or endocrine disorders, and many prescription and non-prescription drugs (including bisphosphonates) can affect your orthodontic treatment. It is imperative that you inform your orthodontist of any changes in your general health status.

Use of Tobacco Products

Smoking or chewing tobacco has been shown to increase the risk of gum disease and interferes with healing after oral surgery. Tobacco users are also more prone to oral cancer, gum recession, and delayed tooth movement during orthodontic treatment. If you use tobacco, you must carefully consider the possibility of a compromised orthodontic results.

Temporary Anchorage Devices

Your treatment may include the use of a temporary anchorage device (i.e. metal screw or plate attached to the bone.) There are specific risks associated with them. It is possible that the screw(s) could become loose which would require its/their removal and possibly relocation or replacement with a larger screw. The screw and related material may be accidentally swallowed. If the device cannot be stabilized for an adequate length of time, an alternate treatment plan may be necessary. It is possible that the tissue around the device could become inflamed or infected, or the soft tissue could grow over the device, which could also require its removal, surgical excision of the tissue and/or the use of antibiotics or antimicrobial rinses. It is possible that the screws could break (i.e. upon insertion or removal.) If this occurs, the broken piece may be left in your mouth or may be surgically removed. This may require referral to another dental specialist. When inserting the device(s), it is possible to damage the root of a tooth, a nerve, or to perforate the maxillary sinus. Usually these problems are not significant; however, additional dental or medical treatment may be necessary. Local anesthetic may be used when these devices are inserted or removed, which also has risks. Please advise the doctor placing the device if you have had any difficulties with dental anesthetics in the past.

If any of the complications mentioned above do occur, a referral may be necessary to your family dentist or another dental or medical specialist for further treatment. fees for these services are not included in the costs for orthodontic treatment.

Acknowledgement

I hereby acknowledge that I have read and fully understand the treatment considerations and risk presented in this form. I also understand that there may be other problems that occur less frequently than those presented, and that actual results may differ from the anticipated results. I also acknowledge that I have discussed this form with the undersigned orthodontist(s) and have been given the opportunity to ask any questions. I have been asked to make a choice about my treatment. I hereby consent to the treatment proposed and authorize the orthodontist(s) indicated below to provide the treatment, I also authorize the orthodontist to provide my health care information to my other health care providers. I understand that my treatment fee covers only treatment provided by the orthodontist(s), and that treatment provided by other dental or medical professionals is not included in the fee for my orthodontic treatment

Patient Name ______________________________ Date ______________________

Signature of Patient/Parent/Guardian ______________________________ Date ______________________

Signature of Orthodontist Group Name ______________________________ Date ______________________

Consent to Undergo Orthodontic Treatment

I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment, and to the above doctor(s) and, where appropriate, staff providing orthodontic treatment prescribed by the above doctor(s) for the above individual. I fully understand all of the risks associated with the treatment.

Authorization for Release of Patient Information.

I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, the above doctor(s) and staff has (have) no responsibility for any further release by the individual receiving this information.

Consent to use of Records.

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment, and retention for purposes of professional consultations, research, education, or publication in professional journals.

Signature of Patient/Parent/Guardian ______________________________ Date ______________________

Good brushing and flossing is essential for successful orthodontic results.

We recommend having a professional cleaning every 6 months.

If brushing becomes poor we will remove braces, end treatment, and you may still be financially obligated.

____

____

____

____

____

____

WELCOME TO OUR TEAM

Financial Contract

Patients Full Legal Name: ______________________________ Date of Birth: _________________ Social Security: _______________

Responsible Party Full Legal Name: ______________________ Date of Birth: _________________ Social Security: _______________

Responsible Party Full Mailing Address: ____

Relationship to Patient: _________________ Responsible Party Cell Phone: _________________ Alternate Phone: ______________

Responsible Party Email: ______________________________ Office Location: _______________ Patient ID#: _________________

1. Treatment Fee $_____________
2. Lifetime Retainers $_____________
3. Less Primary *Estimated* Insurance Payment $_____________
4. Less Secondary *Estimated* Insurance Payment $_____________
5. Less Other (_______________________) $_____________
6. *Estimated* Responsible Party Portion $_____________
7. Less Initial Payment (Due ___________) $_____________
8. Unpaid Balance $_____________

Draft Information

Amount of Total Withdrawal	Monthly Payment Amount	Final Payment Amount	Total # of Monthly Withdrawals	Withdrawal Begin Date		
				Month	Day	Year

Account Information

Checking ( )	Savings ( )	Credit Card ( )		
Name on Account		Name on Credit Card		
Bank Account Number		Card Type		
Routing Number		Card Number		
Bank Name	Zip Code	Expiration Date	Security Code	Zip Code

Arkansas Dentistry & Braces ("ArDB") is providing interest free, in-house financing for the Dental/Orthodontic Treatment defined herein, and I irrevocably and unconditionally agree to pay the Total Fee for the services provided. If insurance and/or Medicaid may cover all or part of the Total Fee, those contributions are estimated herein. Should the insurance and/or Medicaid payments estimated not be received by ArDB for any reason, I agree to immediately pay ArDB for the payments not received. I also agree to make payments in a timely manner, meaning on or before the date my payments are Due Monthly. Should my payments be received late, I agree to pay an additional $10 late penalty. If my Card or Account Number have been provided herein, then I authorize ArDB to auto-draft my payment each month on the day it is Due Monthly or first business thereafter, until such a time as the Total Fee is paid in full. Should an auto-draft attempt fail for any reason, I authorize ArDB to continue attempting to auto-draft my card/ account every day until the payment plus a $25 failed payment fee is collected. I understand that, should I choose to discontinue auto-drafts, I must notify ArDB a minimum of seven days prior to my scheduled draft date. Should my account become delinquent, I acknowledge and accept that ArDB may report the delinquency to one or more credit bureau and that, if more than 90 days' delinquent, my account may be turned over to a third-party collections agency. I acknowledge and accept that this agreement supersedes all prior discussions and agreements between the parties hereto, fully and completely expresses the parties' agreement, may be amended or modified only by written agreement of the parties here to, and shall be construed and interpreted in accordance with the laws of the State of Arkansas.

Responsible Party Signature:____ Date:________________

Employee Signature:____ Date:________________