

JAMES KODAMA D.D.S.
19231 VICTORY BLVD.,#253
RESEDA, CA 91335
(818) 344-1393

FINANCIAL CONTRACT

PATIENT: _____

1. PRE-TREATMENT Orthodontic RECORDS FEE: \$ 195.00
2. ORTHODONTIC TREATMENT COST \$ _____

MONTHLY PAYMENT PLAN:

Down Payment \$ _____

Remaining Balance \$ _____

I agree to pay \$ _____ monthly,

Starting _____ for _____ months.

I will send subsequent payments to arrive by the _____ day of each month.

I understand and agree that any **LATE PAYMENTS** of more than 7 days past due will be automatically billed to a CREDIT CARD number which will be kept on file.

CREDIT CARD # _____ Exp Date _____

Treatment cost does not cover any appliances which may be lost or broken; a replacement fee will be charged. A **\$20** fee will be charged for failed appointments and for returned checks due to insufficient funds.

GENERAL DENTISTRY procedures such as: Cleanings, Mouth guards, Progress X-ray Radiographs, Dental Fillings, Crowns, or Tooth Extractions, are separate procedures and are **NOT** covered by the orthodontic treatment cost.

The Doctor is a General Dentist with post-graduate training in orthodontics. Our dental office is limited to general dentistry orthodontics, and dentofacial orthopedics.

Doctor Kodama has permission to use diagnostic and treatment photographs, models, and records of the patient for the purpose of scientific articles, seminars, and presentations.

I understand that responsibility for payment for dental services provided in this office for myself or my dependent is mine. I hereby authorize that the payment from any insurance company due me be paid directly to Doctor Kodama. I understand that I am responsible for any amounts not covered by my insurance company. In the event of default in payment, patient or party responsible for fees agrees to pay any and all costs of suit, collection, and attorney's fees. Any refunds due me shall be paid when all fees have been paid in full.

Signature: _____ Date: _____