Dental Specialties of Saint Louis University
Orthodontic Clinic Compliance Form

Patient Name: _____ **Patient No.** _____

Patient-Parent/Legal Guardian responsibilities for treatment in the Orthodontic Clinic:

- **Cooperation** of patients is mandatory in following specific and routine directions of the doctor, including the wearing of removable auxiliary devises (headgears, rubber bands, retainers, etc.) and the maintenance of proper oral hygiene.
- **Financial** agreements must be kept current.
- **Appointments** must be kept. Ample notification must be given for changes in scheduling by the patient.

    - **Clinic Appointment Times:**
        1. Tuesday-Friday from 9:00a.m.-3:00p.m.
        2. Appointments are subject to availability.
    - **Approximate Order of Appointments:**
        1. **X-rays**- Parent/Legal Guardian must accompany Patients under the age of 18 to sign financial documents
        2. **Records**-models, photographs, possible additional X-rays
        3. **Consultation**-Parent/Legal Guardian must accompany Patients under the age of 18 to sign Informed Consent to Treatment
        4. **Braces/Appliances/Monthly Appointments**
        5. **Retention/Observation**

*Please note: all appointments are during school and business hours and are made to accommodate our residents' class schedule. Family/friends must remain in the main waiting room while patients are being treated. (Up to three hours of time per appointment may be necessary on occasion, however regular appointments are generally one hour.)

Discontinuation of treatment may occur as a result of:

- Lack of cooperation by the patient and/or parent/legal guardian is demonstrated.
- Numerous appointments are broken or monthly appointments are not scheduled and/or kept.
- The financial agreement is not honored.
- No personal videos or photos may be taken in the clinic and/or posted to social media.

*If for any reason the decision is made to discontinue treatment after X-Rays and Records have occurred, but before braces are placed, $300.00 of the initial payment will be retained by Saint Louis University. All later refunds will be prorated based on the length of time patient has been in treatment.

I have read the above and understand the requirements. Permission is hereby granted to discontinue treatment for the patient in the event the above-stated conditions are violated. Dismissal from the program may result in the patient not being able to return to the program for future treatment.

Signed: _____ **Date:** _____

Relationship to Patient: _____