

Invisalign Patient Consent Form

Congratulations on choosing your smile makeover with Invisalign! We are excited that you have chosen our office to monitor your treatment progress and we look forward to seeing your new and improved smile. We know that people are very busy, so we will work to keep your treatment as efficient as possible.

In order to ensure that you have the best experience possible, please review the following regarding your Invisalign treatment package:

1. By signing below, you understand that **Invisalign** is an orthodontic treatment. Not all orthodontic concerns that currently indicate, or that may later develop, will be addressed within the limited time frame and limited number of aligners available. If additional treatment beyond what you agreed to in your simulation is needed, or desired, I **_____** will take responsibility for (additional) fees for this treatment.
2. The Comprehensive Package includes up to 25 aligners. 1st appointment: to place attachments, perform interproximal reduction, and deliver first set of aligners. 2nd appointment: to monitor the fit and progress of your treatment and perform any necessary interproximal reduction. There will be multiple appointments after the 2nd for any reduction needed. The final appointment to remove any attachment and deliver your retainers.
3. Invisalign retainers are included in your package, for an additional \$400 you may upgrade your retainers to the Viverra Retainers- a thicker material.
4. The recommended wear time for your Invisalign aligners is 20-22 hours each day. If you do not wear your aligners the recommended amount of time this may delay treatment and you may not achieve the results you desire, or the tooth movements will not fully express. Additional treatment will be an additional charge.

Please select the treatment type that is desired:

- Invisalign Comprehensive – Includes Unlimited Office Visits during active treatment. All other serviced provided will be subject to additional fees.

By selecting Invisalign, I am aware that failure to comply with wearing my retainer after treatment that could result in a relapse of my teeth and I will not hold Schreder Family Dental liable.

Initial: **_____**

Name _____

Date _____

Signature _____

Witness _____

Down Payment _____

Monthly payment amount _____

