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COMPLIANCE AGREEMENT

- I understand that it is essential to wear and look after my appliances, including any prescribed elastics (if applicable), as per instructions given, both verbal and written.
- I understand it is important to always have active orthodontic appliances monitored and that it is essential to attend regular appointments and/or take my Dental Monitoring scans on time (if applicable).
- If less than 48 hours' notice is given for an in clinic appointment cancellation, the unused clinical time will be charged for accordingly.
- I understand that continuing to fail to meet all of the above requirements, means compromising my treatment and if additional treatment time or treatment changes are required, it will be chargeable.
- I understand the above agreements will be reviewed at an in practice appointment in 8 weeks and if the above is still not being met it may be recommended that treatment is discontinued.

Patient name: _____

Responsible Party name (if applicable): _____

Relationship to patient (if applicable): _____

Date: _____

Patient Signature: _____

Responsible Party Signature: _____