SMILEWELL

RETAINERS FOR LIFE

Protect your investment through Retainers For Life®

BEGINNING OF TREATMENT PROTECTION PLAN
Please select one.

- ☐ **Option 1:** Retainers for Life Protection Plan Pay In Full $880 (both arches) **OR** $440 (one arch)
- ☐ **Option 2:** Protection Plan Payment Options- $880/X months of treatment (both arches)
  OR $440/X months of treatment (one arch)

I _____authorize **Retainers For Life** to charge my account indicated below each month or pay in full for payment of my/my child's retainers.

Name of Patient: _____ DOB:_____

Phone Number:_____ Email Address:_____

PHASE I / TRADITIONAL (circle one) UPPER / LOWER / BOTH (circle one)

Credit Card:

☐ Visa ☐ Mastercard ☐ Discover ☐ Amex ☐ HSA ☐ FSA

Card Holder Name:_____ Card Number:_____

Exp Date:_____ CVV:_____ Withdrawal Date:_____

Billing Address:_____

Signature: _____ Date:_____

I understand that this authorization will remain in effect until I cancel, and I agree to notify the above named business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my credit card company; so long as the transactions correspond to the terms.