



Quick Enrollment Form (membership only)

Use as needed, circle option & shred after processing

ONE ARCH: UPPER / LOWER (circle one)

Coupon Code _____

OPTIONS	WEBSITE RETAIL PRICE	IN TREATMENT 25%
Pay In Full	\$625	\$325
Payment Plan	3 months x \$153.33	3 months x \$115 (\$345)

BOTH ARCHES

OPTIONS	WEBSITE RETAIL PRICE	IN TREATMENT 25%
Pay In Full	\$1250	\$650
Payment Plan	6 months x \$153.33	6 months x \$115 (\$690)

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:** _____

Shipping Address: _____ **PHASE I / TRADITIONAL (circle one)**

Phone Number: _____ Email Address: _____

Credit Card:

Visa Mastercard HSA FSA

Card Holder Name: _____ Card Number: _____

Exp Date: _____ CW: _____ Withdrawal Date: _____

Billing Address: _____

Payment Option:

Pay In Full Payment Plan Length & Amount: _____

Signature: _____

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.

Quick Enrollment Form (membership with retainer)

RETAINERS FOR LIFE

Upon enrollment you will have access to replacement retainers for a small co-pay at wholesale price starting at only \$43* shipped to your door for life.

ONE ARCH: UPPER / LOWER (circle one)

Coupon Code _____

OPTIONS	WEBSITE RETAIL PRICE	IN TREATMENT 25%
Pay In Full	\$625	\$349.50
Payment Plan	3 months x \$215	3 months x \$123.17 (\$369.51)

BOTH ARCHES

OPTIONS	WEBSITE RETAIL PRICE	IN TREATMENT 25%
Pay In Full	\$1250	\$699
Payment Plan	6 months x \$215	6 months x \$123.17 (\$739.02)

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:** _____

Shipping Address: _____ **PHASE I / TRADITIONAL** (circle one)

Phone Number: _____ Email Address: _____

Credit Card:

Visa Mastercard HSA FSA

Card Holder Name: _____ Card Number: _____

Exp Date: _____ CW: _____ Withdrawal Date: _____

Billing Address: _____

Payment Option:

Pay In Full Payment Plan Length & Amount: _____

Signature: _____

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.

