Invisalign Patient Transfer Form

This Patient Transfer Form notifies and authorizes Align Technology, Inc. its representatives, successors, assigns and agents (together "Align"), to transfer all of the patient's electronic Medical Records (described below) in its possession to New Treating Provider listed below.

PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED UNPROCESSED

Patient information.

Patient name (Last, First) _____

Date of birth dd/mm/yyyy _____ / _____ / _____

Patient ID number _____

Patient Medical Records.

"Medical Records" include, but are not limited to, x-rays, scans, reports, charts, prescriptions, medical history, photographs, findings, plaster models or impressions of teeth, diagnosis, medical testing, test results, billing, and other treatment records on file with Align for treatment purposes.

RELEASE of patient by **Current Treating Provider.**

Please transfer the patient listed above out of my Invisalign Doctor Site including the patient's ClinCheck® files. I understand that by doing so, I relinquish all control of this patient to the New Treating Provider listed below. Align shall not be responsible for any cost, liability, or obligation resulting from my decision to transfer the patient to another provider for treatment or from transferring the Medical Records. I acknowledge that I am still responsible for any open balance incurred for this patient's treatment prior to the transfer.

Provider's Name (Please Print) _____

Provider's Invisalign ClinID _____

Provider's Signature _____

Date Signed _____

ACCEPTANCE of patient by **New Treating Provider.**

Please transfer the patient listed above into my Invisalign Doctor Site including the patient's ClinCheck files. I understand that by doing so, I accept and will assume full responsibility of any future Invisalign treatment charges. Align shall not be responsible for any cost, liability, or obligation resulting from transferring the patient or from my decision to accept the patient for treatment.

Provider's Name (Please Print) _____

Provider's Invisalign ClinID _____

Provider's Signature _____

Date Signed _____

Practice address (include street, city & postcode) _____

In some instances, Align may transfer a patient without authorization from the Current Treating Provider if the request is signed by both the patient and the New Treating Provider.

For the patient - Patient request and authorization for transfer.

This Patient Transfer Form authorizes correspondence with Align and any provider named above, verbally or in writing, regarding Medical Records and the transfer thereof, or other related information that may be (i) considered confidential under a national or state health, safety, or privacy code or (ii) otherwise considered individually identifiable health information.

I will not, nor shall anyone on my behalf, have any rights of approval, claims of compensation, or seek or obtain legal, equitable, or monetary damages or remedies arising out of use of my Medical Records that comply with the terms of this Patient Transfer Form. A copy of this Patient Transfer Form shall be considered as effective and valid as the original. This authorization shall be valid three years from the date I sign below.

I have read and understand the contents of this Patient Transfer Form.

Patients Name (Please Print) _____

Patient's Signature _____

Date Signed _____

If patient lacks the legal capacity to sign, the parent or legal guardian must also sign this form.

Legal Guardian / Parent Name and Relationship _____

Parent's Signature _____

Date Signed _____

Please send completed Patient Transfer Forms to your local Invisalign Customer Care by email to casetransfers@aligntech.com or by fax to: 408-790-0670

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American Association of Orthodontists

AAO TRANSFER FORM
PATIENT IN ACTIVE TREATMENT

Date _____

To _____

From _____

Phone (_____) _____ - _____ Fax (_____) _____ - _____

Patient's name _____ Birth date _____ Age _____ Sex _____

Social Security # _____- ___ - _____ Phone (_____) _____ - _____

Responsible party _____ Relationship: _____

Home address _____ City _____ State/Province _____ Zip code _____

ANALYSIS (Including significant history & TMD) _____

PATIENT/PARENT CONCERNS RE: TX _____

SPECIAL HEALTH OR HISTORY CONCERNS _____

TREATMENT PLAN (Including chronology of treatment rendered) _____

APPLIANCES

Appliance (type, manufacturer, type of bracket–metal or non-metal, and variations) _____
Date bands and/or brackets placed: Max _____ Mand _____ Bonding Agent _____ Cementing Agent _____
Current archwire size and type: Max _____ Mand _____
Extraoral type and dates initiated _____ Hours requested _____
Intraoral elastics, dates initiated, size and direction _____ Hours requested _____
Removable appliance type and dates initiated _____ Hours requested _____

PATIENT COOPERATION

Oral hygiene _____ Headgear _____ Elastics _____
Appointments _____ Broken appliances _____
Patient's attitude toward treatment _____
Suggestions for patient motivation _____

ACTIVE TX TIME ESTIMATES Original _____ Remaining _____ % of active treatment completed _____

ACTIVE TREATMENT RECOMMENDATIONS _____

RETENTION AND THIRD MOLAR RECOMMENDATIONS _____

ADDITIONAL COMMENTS _____

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Transfer – Active 5/00
Reviewed 09/09

FINANCIAL

Closed _____ Open End (Fixed) _____ Other _____

Fees: Active _____ Extras _____

Terms _____

Third party payment _____

Total charges before transfer _____

Total amount paid before transfer _____

Unpaid amount still owed transferring office _____

Balance of original quoted fee not yet charged _____ or overpaid at transfer _____

TRANSFER OF RECORDS **(Enter date)** _____

Dates of our: Records _____

Casts _____ Articulator type _____

Cephalograms _____ Tracings _____

Intraoral radiographs _____

Facial photographs _____

Intraoral photographs _____

Transferring Duplicate ☐ Initial ☐

Original ☐ Progress ☐

Check appropriate status of records

Record duplicates available upon request at extra charge ☐Yes ☐No

Records enclosed ☐Yes ☐No

Under separate cover ☐Yes ☐No

Signature: _____Date_____

(Orthodontist)

PATIENT RECORDS RELEASE AUTHORIZATION

When a patient moves, or, for other reasons, there is a necessity to change orthodontists during the course of ongoing orthodontic treatment, it is highly advantageous for all involved parties that the transfer be as prompt and convenient as possible. Of paramount importance is the identification of an orthodontist who will accept the patient and successfully complete the treatment.

The American Association of Orthodontists represents over ninety percent of the orthodontic specialists in the U.S. and Canada. Your current doctor is a member and will assist you in finding a qualified orthodontist.

It is necessary that your records be transferred to assure that the receiving orthodontist is knowledgeable of your orthodontic condition(s), orthodontic treatment goals, the current treatment plan, and related financial arrangements. To facilitate the transfer of these records, it is necessary that you complete the following:

I authorize _____ to release all records of

(Orthodontist's Name)

_____ for the purpose of continuation of treatment by another orthodontist.

(Patient's Name)

Signature: _____Date_____

(Patient or Guardian)

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Print Name _____

Relationship to Patient _____

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