

REQUEST FOR PATIENT CONSULTATION



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P.O. Box 1665 • Birmingham, MI 48012
(248) 850-1433

PATIENT NAME: _____ MALE FEMALE

DATE OF BIRTH: _____ DATE RECORDS MADE: _____

PLEASE SEND ME:

Complete consultation, including diagnosis, treatment plan, mechanics plan, retention plan and suggested fee.
\$300.00 U.S. per case

Note: A patient consent form must be included with the patient records. A copy of the consent form will be e-mailed to Dr. Litt along with all of the other patient records from D.E.T.

This consultation report does not constitute a contract between Dr. Richard A. Litt (consultant) and the above named patient. No in-person Dr./patient relationship has ever been established between Dr. Litt and the above named patient. The enclosed case description and treatment plan are for educational purposes and describe one of the acceptable treatment options for this patient. The final decision regarding the diagnosis and treatment of the problem, as well as the cost, timing, and choice of appliances to be used, rest solely with the treating doctor. These decisions must be made in concert with the above named patient or parents, if said patient is a minor.

Payment to F.O.R.C.E., Int. must be included with the records and order form

NAME: _____

CREDIT CARD BILLING ADDRESS: _____

CITY: _____ STATE/PROVINCE: _____ ZIP/POSTAL CODE _____

PHONE: (_____) _____ FAX: (_____) _____

E-MAIL FOR CONSULTS: _____

I WILL PAY BY: VISA MASTERCARD AMOUNT PAYABLE TO F.O.R.C.E., INT.: \$ _____

ACCOUNT NUMBER: _____ EXP. DATE: _____

SEC OR 3-DIGIT CODE: _____ SIGNATURE: _____