**Elizabeth Spannhake, DDS, PA**
PRACTICE LIMITED TO ORTHODONTICS
**7801 YORK ROAD**
**SUITE 315**
**TOWSON, MD 21204**

## CONSENT FORM FOR ORTHODONTIC CARE FOR MEDICAL ASSISTANCE PATIENTS

INSTRUCTIONS: Read this form carefully. If you have any questions, ask them before you sign the form. Each page MUST be signed and dated before Dr. Spannhake will make any application for orthodontic treatment for your child through the Medical Assistance Program.

PATIENTS NAME: _____ MA#_____

ADDRESS :_____

CITY :_____STATE :_____ZIP :_____ PHONE:_____

I am making an application for the above named patient for orthodontic treatment in the office of Elizabeth Spannhake, DDS. The patient has Medical Assistance benefits, and I desire that s/he be treated under the Medical Assistance Orthodontic Program.

I have been advised that although Medical Assistance may initially pay for treatment, the patient will only be eligible under that program as long as his/her Medical Assistance card remains valid. The Medical Assistance Program reimburses the orthodontist on a monthly basis.

I understand that as long as Medical Assistance covers the patient, Dr. Spannhake's office agrees to treat the patient for Medical Assistance reimbursements only. If the patient becomes ineligible for Medical Assistance benefits during the course of treatment, Dr. Spannhake may, at her discretion, either discontinue the patient's orthodontic care or continue treatment on an out of pocket payment basis, using the courtesy fee of **$200.00** per month while the child is wearing either fixed or removable appliances, for active orthodontic treatment. I understand that this monthly amount would be due EVERY MONTH, regardless of whether or not the patient appeared for an appointment that month..

I am aware of the out of pocket fee that would apply should the patient lose Medical Assistance benefits, and I understand that if Dr. Spannhake, accepts the patient under private care, I must pay for those services not covered by Medical Assistance. If Dr. Spannhake accepts the patient under the out of pocket payment plan, I promise to make the **$200.00** payment by the twenty-fifth of each month. If the payment is not made by the twenty-fifth of the month, I understand that orthodontic care may be discontinued.

Should the patient regain retroactive Medical Assistance benefits after I have agreed to pay Dr. Spannhake for out of pocket care, I understand that Dr. Spannhake will reimburse me for any monthly payments made for the retroactively covered period, and then apply to Medical Assistance for reimbursement for the services performed during this period.

SIGNED_____ DATE:_____

RELATIONSHIP TO PATIENT:_____

PATIENT:_____

SHOULD I DECIDE TO DISCONTINUE THE PATIENT'S ORTHODONTIC CARE WITH DR. SPANNHAKE, I AM AWARE THAT:

1. I must accept full responsibility for this decision and the consequences of incomplete treatment
2. I understand that Dr. Spannhake recommends removal of the braces to prevent injury or dental disease, and that I am responsible for choosing whether or not to have the braces removed.
3. I realize that terminating orthodontic care before a patient completed treatment, may result in poor dental function and possible shifting of the bite, especially if teeth have been removed.
4. I know that Dr. Spannhake is not obligated to continue my child's orthodontic care if Medical Assistance coverage has expired. All responsibility for discontinuing care reverts to me. Likewise, the decision not to assume payment of fees set by Dr. Spannhake's office as stated on page one of this consent form will give Dr. Spannhake permission to remove the braces and discontinue my child's orthodontic care.

IN ADDITION, DR. SPANNHAKE'S OFFICE HAS MADE ME AWARE THAT IN GRANTING A COURTESY FEE FOR THE MEDICAL ASSISTANCE FINANCED CARE, SHE REQUIRES THAT I ALSO AGREE THAT:

1. The patient will visit their general dentist for routine check-ups and preventive care every six months or whenever Dr. Spannhake feels special care is needed.
2. I will make certain that the patient attends regularly scheduled visits with Dr. Spannhake's office. I am also aware that a majority of the regular appointments will involve a loss of school time. If the patient misses an appointment, it is my responsibility to see that the treatment is made up at the convenience of Dr. Spannhake's office.
3. I will promptly inform Dr. Spannhake's office of any changes in Medical Assistance eligibility, the patient's address, home phone number(s) and/or work/cell numbers.
4. I will make myself available for consultation when required by Dr. Spannhake.

_____ _____

Signature Date

_____

Print Name