Elizabeth Spannhake, DDS, PA.
7801 York Road, Suite 315, Towson, MD 21204
419 Malcolm Drive, Suite C, Westminster, MD 21157

Date: _____

Patient: _____

I understand that all fees associated with my initial orthodontic consultation, diagnostic radiographs and photographs taken during today's office visit, and any treatment completed will be submitted to my insurance company.

I also understand I am responsible for any portion of the fee (co-insurance/co-pay) that my insurance company does not cover, and if not paid within 90 days, my account will be sent to a collection agency and I will be responsible for all fees charged by the agency.

The fees associated with today's office visit are not part of the orthodontic treatment fee.

Signature of responsible party: _____
(seal)

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