ORTHODONTIC INFORMED CONSENT FORM

Provider Office

Provider Name:						**Office ID#:**	
Address:						**Office Phone:**	
City:		**State:**		**Zip:**		**Office Fax:**	

Member

Member Name:						**Member ID#:**	
Address:						**Date of Birth:**	
City:		**State:**		**Zip:**		**Phone:**	

To Our Valued Member:

Under the provisions of the NJ FamilyCare program, before the member begins orthodontic treatment, we are obligated to inform you of several key facts and important responsibilities you must be aware of to help ensure the successful completion of the orthodontic treatment.

This form, together with our conversation about treatment alternatives, risks and outcomes, is intended to provide you with a complete understanding of your responsibilities for your orthodontic care.

I _____ have been informed of the following:

Member or Guardian Name

- The age limit for orthodontic coverage;
- The length of treatment;
- The consequences of excessive breakage of appliance(s) and/or other behavior that is not conducive to completing treatment in a timely manner;
- Your responsibility for payment should coverage be lost for any reason; and
- The anticipated completion date if treatment proceeds as planned.

I certify that I have read the above and fully understand this consent.

_____	_____	_____	_____
Signature of Responsible Party	Relationship to Patient	Date	Witness