REASON FOR CONSULTATION

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DOES THE PATIENT HAVE ANY SPEECH PROBLEMS?						
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HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? Yes No	HAVE YOU BEEN INFORMED OF AN	Y MISSING OR EXT	RA PERMANENT TEETH	H?Yes ☐	No 🗌	
HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY?Yes No	HAS AN ORTHODONTIST BEEN COI	NSULTED PREVIOU	SLY?	Yes [] No□	
HAS EITHER PARENT HAD ORTHODONTIC TREATMENT?Yes No	HAS EITHER PARENT HAD ORTHOG	OONTIC TREATMEN	T?	Yes [No 🗌	
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Dr. Michael B. Montanaro D.D.S., P.C.

CONSENT FOR USE A	ND DIS		OF HEALTH
SECTION A: PATIENT GIVING CONSENT			
PATIENT NAME:			
			-
	CITY	STATE	ZIPCODE
TELEPHONE:			
Purpose of Consent: By signing this form, you will consent to payment activities and healthcare operations. Notice of Privacy Practices: You have the right to read our No Notice provides a description of our treatment, payment activiti protected health information, and of other important matters abwhich will contain the changes. Those changes may apply to an You may obtain a copy of our Notice of Privacy Practices, in CONTACT PERSON: Dr. M.	otice of Privacy les and healthca out your protect by of your protect neluding any re- lichael Mon	Practices before you decide we re operations, of the uses and red health information. A copy cted health information that we evisions of our Notice, at any stanaro	whether to sign this Consent. Our disclosures we may make of your of our Notice of Privacy Practice e maintain.
ADDRESS: 5294 Park Aver	nue, Bridgep	ort, CT. 06604-1018	
TELEPHONE: (203) 371-0		FAX: (203) 372-	<u>-3700</u>
EMAIL: dr.mi	chaelmontar	naro@gmail.com_	
Right to Revoke: You will have the right to revoke this Conser Contact Person listed above. Please understand that revocation of before we received your revocation, and that we may decline to Consent.	of this Consent	will not affect any action we t	ook in reliance on this Consent
SIGNATURE:			
Ι,	have had	full opportunity to read and co	onsider the contents of this Consen
form and your Notice of Privacy Practices. I understand that, by protected health information to carry out treatment, payment ac	signing this Co	onsent form, I am giving my c	onsent to use and disclosure of my
Signature:	D	ate:	
If this Consent is signed by a personal representative on beh			
PERSONAL REPRESENTATIVE'S NAME:			
RELATIONSHIP TO PATIENT: *YOU ARE ENTITLED TO A C	OPY OF THIS	CONSENT AFTER YOU SIG	GN IT.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

(Include a completed Consent in the patient's chart)

Dr. Michael B. Montanaro D.D.S., P.C.

Practice Limited to Orthodontics

5294 Park Avenue Bridgeport, CT 06604 Phone (203) 371-0119 Fax (203) 372-3700 montanaroorthodontics.com

Dear Valued Patient,

To Clarify Many Misconceptions Regarding Your Insurance:

- *Treatment recommendations are based on your or your child's needs, not on your insurance or lack thereof.
- *If you have orthodontic coverage included in your dental insurance, you must present insurance card or information for insurance company, so that we may be able to submit a claim in your behalf.
- *We will provide you with a <u>estimate of benefits</u> (EOB), which takes anywhere between 4-6 weeks (longer if you do not provide all the information needed for our office to expedite your claim) to come from your insurance provider. However, you are fully responsible for any treatment performed, which may not be covered by insurance (replacement and/ or broken retainers, bleaching, bonding, etc.)
- *Remember: Your benefits are a contract between you, your employer and your insurance company.
- *We will not be responsible for what your insurance will or will not cover.
- *As a reminder, it is not our responsibility to keep track of your insurance changes or termination. Should you have a change in insurance benefits, please contact us or provide us with the new insurance information. If you are terminated or your insurance is cancelled, you are responsible for your balance, including what the insurance company owes. (For orthodontics, insurance should be kept for at least a minimum of 2 years to fully pay out benefit lifetime max.)
- *As always, we will submit your orthodontic claim at no extra cost to you.

Patient or parent signature	
Date//	