MOUNTAIN RIDGE
DENTISTRY

Welcome to Mountain Ridge Dentistry! We are grateful for the opportunity to positively impact your dental health.

We opened in September 2018 to provide excellent and ethical dental care in our growing community. Our family owned and patient-focused practice utilizes the latest in modern dental technology to provide you with the most comfortable, efficient, and effective care available in the industry.

If you are ever unsure of your dental health or treatment options, please inform us right away. We want you understand your options, so you may confidently make informed decisions about your health.

Our team looks forward to serving you!

Love,

The Mountain Ridge Dentistry Team

MOUNTAIN RIDGE DENTISTRY

# Patient Health Information

| General Information | |
|---|---|
| First and Last Name: | |
| Preferred Name: | |
| Date of Birth: | |
| Emergency contact name: | |
| Emergency contact phone: | |
| Spouse's Name: (if married) | |
| Physician Name: | |

| Contact Information | |
|---|---|
| Cell/Home Phone: | |
| Address: | |
| City: | |
| State: | |
| Zip: | |

| Employment Information | |
|---|---|
| Employer: | |
| Work Phone: | |

| Optional HIPAA Contact | |
|---|---|
| To authorize someone to have access to your privileged HIPAA health information, please provide their information below. **Leave this blank if you do not wish to authorize anyone**. | |
| First and Last Name: | |
| Relationship: | |
| Birthday (verification purposes): | |
| Phone Number: | |

| Medical History | |
|---|---|
| | Cancer, tumor, radiation treatment (circle all that apply) |
| | Heart ailment or angina (circle one) |
| | Heart murmur, mitral valve, heart defect (circle one) |
| | Rheumatic fever or rheumatic heart disease (circle one) |
| | Artificial joint or valve (circle one) |
| | High or low blood pressure (circle one) |
| | Pacemaker |
| | Tuberculosis or lung problems (circle one) |
| | Kidney disease |
| | Hepatitis or other liver disease (circle one) |
| | Alcoholism |
| | Blood transfusion |
| | Diabetes |
| | Neurologic condition |
| | Epilepsy, seizures, or fainting spells (circle one) |
| | Emotional condition |
| | Arthritis |
| | Herpes or cold sores (circle one) |
| | AIDS or HIV positive (circle one) |
| | Migraine headaches / frequent headaches (circle one) |
| | Anemia or blood disorders (circle one) |
| | Abnormal bleeding after extractions, surgery, or trauma (circle one) |
| | Hayfever or sinus trouble (circle one) |
| | Allergies or hives (circle one) |
| | Asthma |
| | Comments / Additional Conditions: |



_____

**Patient/Responsible Party Signature**

_____

**Date**

310 Mountain Avenue, Berthoud CO 80513 ~ 970.528.0900 ~ **mountainridgedentistry.com**

MOUNTAIN RIDGE DENTISTRY

# Patient Health Information

**Page Two**

| Current Health |
| --- |
| Do you use tobacco? (Please specify: chew, smoke, vape, etc.) |
| Do you use alcohol? If so, how frequently? |
| List ALL Allergies: |
| List ALL Current Medications and Prescriptions (include over the counter medications): |
| Pregnant? Y N |

| Dental Health |
| --- |
| Do you clench or grind your teeth? Y N<br>*Optional explanation:* |
| Do your gums ever bleed? Y N<br>*Optional explanation:* |
| How do you feel about visiting the dentist? |
| Anything else not listed on this sheet? |



_____

**Patient Printed Name**

_____ _____

**Patient/Responsible Party Signature** **Date**

*We protect and encrypt your information to ensure confidentiality.*

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MOUNTAIN RIDGE
DENTISTRY

# Consent For Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I may ask for a recital of any possible complications.

4. I give consent to the doctor and his designated staff the use and disclosure of oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I understand I am responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 2% late charge may be added to my account and I will be sent to collections for nonpayment.

_____ _____

Patient Name Date

_____

Patient/Responsible Party Signature

MOUNTAIN RIDGE
DENTISTRY

# Cancellation Policy

When you schedule an appointment, we reserve the following for you:

- Doctor
- Hygienist
- Assistant
- Dental Room and Chair
- Materials & Supplies
- Equipment

Appointment no-shows and short-notice cancellations create expensive challenges and stressors on our team, resources, and time. It also absorbs time that would have been utilized by another patient needing dental care. Your appointment is an agreement between you and Dr. DePorter, and we never double book.

Still, we understand life happens. Kindly provide us with a minimum of 48 hours notice for cancellation or reschedule requests. A $25 fee will be charged for reschedules, cancellations, and no-shows that violate our 48-hour policy. A fee of $50 thereafter for each consecutive missed appointment will be assessed.

Your oral health is our top priority, and we take your treatment seriously. We sincerely appreciate your cooperation with our cancellation policy.

_____ _____

Patient Name Date

_____

Patient/Responsible Party Signature

MOUNTAIN RIDGE
DENTISTRY

# Financial Policy

If you have questions about treatment, options, or fees, please ask for clarification before treatment begins. Our priority is to provide you with excellent dental care. Our financial policy is as follows:

**Insured Patients**

- Insurance benefits are a contract between the patient and insurance company. Insurance is not a contract between our office and your insurance company. We are happy to assist in filling your insurance claim and providing the details they require. **We are not, and cannot be, responsible for payment/non-payment by your insurance company. You are always responsible for balances not paid by your insurance plan.** Insurance companies always look for ways not to pay, and we are not responsible for their actions.
- If you are non-insured, or tired of dealing with insurance companies, we are happy to provide a membership plan to ensure affordable dental care is available to all community members.
- If your insurance claim is denied, full payment is due immediately. If you file an insurance appeal, you will be reimbursed pending the results of the appeal.

**Payment**

- We accept cash, personal checks, and most major credit cards. Payment is always due at time of service. In-house payment plans are available at your request.
- Treatments costing more than $300 require a $50 booking deposit. This deposit is applied to your treatment balance, and is used to reserve the room, chair, supplies, and team members specifically for you at the exclusion of other patients. If you prepay in full for service, this deposit will not be collected.
- You are responsible for timely and full payment of services rendered. If payment is not provided within 60 days or a cancellation violation occurs, we reserve the right to charge any card used in our office previously or on file for payment. If we are forced to refer your unpaid balance to a collection agency, attorney, or court, you are responsible for all legal fees and costs associated.

I understand the above agreement, and agree to the terms and conditions outlined in this document.

Patient Name: _____ Date: _____

Patient Signature: _____

# Notice of Privacy Practices



We are required by law to maintain the privacy of protected health information, to protect individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this notice while it is in effect. We reserve the right to adjust our privacy practices at any time as permitted by law. If this notice is significantly changed, we will post the new notice and make copies available at your request. You may also request a copy of this notice at any time. For more information, please contact us.

## How Your Health Information May Be Used and Disclosed

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. Examples of such instances are listed in this document. Some HIV, genetic, alcohol/substance abuse, and mental health records may be entitled to special confidentially protections under federal law. We abide by these special protections as they apply.

**Treatment**: We may use and disclose your health and treatment information to a referred specialist you have accepted additional treatment from.

**Payment**: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved in your care. This involved billing, collections, claims, and coverage eligibility to obtain payments from you, and insurance company, or another third party.

**Healthcare Operations**: We may use or disclose aspects of your treatment and/or healthcare in connection with optimizing our operations. This includes quality assessment, improvement activities, training, and licensing activities. Your information remains confidential within our team.

**Individuals Involved in Your Care or Payment for Your Care**: We may disclose your health information to your family or friends, or any other individual identified by you, when they are involved in your care or in the payment of your care. We may disclose information about you to a patient representative. If that person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you in respect to your health information.

**Disaster Relief**: We may use or disclose your health information to assist in disaster relief efforts.

**National Security**: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of the protected health information of an inmate or patient.

**Secretary of HHS**: We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation**: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement**: We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities**: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care systems, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings**: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may disclose health information about you in response

MOUNTAIN RIDGE DENTISTRY

# Notice of Privacy Practices



to a subpoena, discovery request, or other lawful process instituted.

**Required by Law**: We may use or disclose your health information when we are required to do so by law. We will obtain your written authorization before using or disclosing your PHI for purposes other than those stated in this notice (or otherwise permitted by law).

### Your Health Information Rights

**Access**: You have the right to view or obtain copies of your health information, with limited exceptions. You must make this request in writing by letter to the address listed on the bottom of this page. We may charge you a reasonable cost-based fee for the cost of supplies and labor of copying/postage/etc. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Right to Request a Restriction**: You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to our Business Manager. Your written request must include the information you wish to limit, whether you want to limit our use, disclosure, or both, and to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying our payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Coroners, Medical Examiners, and Funeral Directors**: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. Other scenarios may apply consistent with applicable law.

**Alternative Communication**: You have the right to request communication with us by alternative means or locations. This request must be made in writing and specify the alternative means and/or location, along with a satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate reasonable requests, however we may contact you with the information we have on file if we are unable to contact you via your requested ways.

**Amendment**: You have the right to request amendments to your health information. You must request in writing, and thoroughly explain why existing health information should be amended. If we agree to your request, you will be notified of such. If we deny your request, we will provide you with written explanation of the denial and explain your rights.

**Right to Notification of a Breach**: You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice: You may receive an electronic copy of this privacy notice at any time at your request.

**Questions and / or Concerns**

Contact us for more information about our privacy practices or have questions or concerns. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

I understand the above privacy agreement, and agree to the terms and conditions outlined in this document.

Patient Name: _____ Date:_____

Patient/Responsible Party Signature: _____