SELECT CARE
DENTAL

PATIENT INFORMATION

NAME OF PATIENT _____ _____
First Middle Last Birthday Age

Preferred Name_____

Resident Address_____
Street No. City State Zip

Mailing Address_____
Street No. City State Zip

Cell Phone No. _(____)_____ ☐ Home Phone No. _(____)_____ ☐
Please check your best contact phone #

Email Address_____

RESPONSIBLE PARTY

Self/Parent_____

Social Security No._____

Driver's License No._____

Cell Phone No. _(____)_____

Is there a dental insurance company that you would like us to bill? Primary ☐ Secondary ☐

Whom may we thank for referring you to our office?

_____

IN CASE OF EMERGENCY CONTACT:_____
Name **Relationship** **Phone #**

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and / or health practitioners. I give my permission for Select Care Dental to leave messages on my homeand/or cell voicemail or with my spouse/partner/caregiver regarding treatment, billing and appointment information. I authorize and request myinsurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment or co-payment is due on the day of service.

X_____ _____
Signature of Patient (Or Parent If Minor) *Date*

SELECT CARE DENTAL Redmond

PATIENT MEDICAL HISTORY

Physician_____ Office Phone_(____)_____ Date of Last Exam_____

	Yes	No
1. Are you currently under medical treatment now or being tested for a medical condition? If yes, please explain _____	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain_____	☐	☐
3. Please list any medications or supplements that you are currently taking_____	☐	☐
4. Do you use tobacco? Frequency_____	☐	☐

5. **Dental History:**

Name of Previous Dentist_____

Location of Previous Dentist_____

Date of Last Exam_____

	Yes	No
- Have you ever been pre-medicated with antibiotics prior to a dental appointment? If so, why_____	☐	☐
- Do you feel pain in any of your teeth?	☐	☐
- Do you have any sores or lumps in or near your mouth?	☐	☐
- Have you had any head, neck or jaw injuries?	☐	☐
- Have you ever experienced any of the following problems in your jaw?		
- Clicking……..	☐	☐
- Pain (joint, ear, side of face)……..	☐	☐
- Difficulty in opening or closing…….	☐	☐
- Difficulty in chewing……	☐	☐
- Do you clench your teeth?.....	☐	☐
- Have you ever had any prolonged bleeding following dental extractions?.....	☐	☐
- Do you like your smile?.....	☐	☐

	Yes	No
6. Are you allergic to or had any reactions to the following?		
- Local Anesthetics (e.g. novocaine) ……	☐	☐
- Penicillin…….....	☐	☐
- Other Antibiotics……..	☐	☐
- Codeine.....	☐	☐
- Sulpha…….....	☐	☐
- Sedatives…….....	☐	☐
- Asprin…….....	☐	☐
- Any Metals, If yes what kind_____	☐	☐
- Latex Rubber…….	☐	☐
- Other Allergies…….....	☐	☐
- WOMEN ONLY		
- Are you pregnant or think you may be pregnant?.....	☐	☐
- Are you nursing?.....	☐	☐
- Are you taking oral contraceptives?.....	☐	☐

7. Do you have or have you had any of the following?

	Year Diagnosed		
- Angina…….....	_____	☐	☐
- Arthritis……..……	_____	☐	☐
- Asthma……..……	_____	☐	☐
- Bisphosphonate Therapy……..……..	_____	☐	☐
- Cancer……Type_____……..	_____	☐	☐
- Cardiac Pacemaker……...	_____	☐	☐
- Celiac Disease……..…….	_____	☐	☐
- Diabetes…..Type_____……..…..	_____	☐	☐
- Emphysema…….....	_____	☐	☐
- Epilepsy/Convulsions…….....	_____	☐	☐
- Glaucoma…….	_____	☐	☐
- Heart Attack……..……	_____	☐	☐
- Heart Disease... …….	_____	☐	☐
- Heart Murmur…….	_____	☐	☐
- Heart Valve Replacement…….	_____	☐	☐
- Hepatitis…..Type____……..	_____	☐	☐
- High Blood Pressure……..……	_____	☐	☐
- High Cholesterol……...……..…	_____	☐	☐
- Aids or HIV Infection…….....….	_____	☐	☐
- Irritable Bowl Syndrome……...	_____	☐	☐
- Jaundice……..……	_____	☐	☐
- Joint Replacement…Type_____.....	_____	☐	☐
- Kidney Disease……..….	_____	☐	☐
- Leukemia……..……	_____	☐	☐
- Low Blood Pressure……..……	_____	☐	☐
- Mitral Valve Prolaps……..……	_____	☐	☐
- Osteoporosis……..……	_____	☐	☐
- Radiation Therapy……..……	_____	☐	☐
- Respiratory Problems…….....	_____	☐	☐
- Rheumatic Fever……..……..……	_____	☐	☐
- Seasonal Allergies……..……	_____	☐	☐
- Sinus Problems. …….....	_____	☐	☐
- STD……Type_____…….....…	_____	☐	☐
- Stroke……..….	_____	☐	☐
- Thyroid Problems……..……..…	_____	☐	☐
- Tuberculosis……..…..….	_____	☐	☐
- Other, Please List_____			

Patient Signature_____ Date

SELECT CARE DENTAL Redmond

Office Policies

APPOINTMENTS

- At Select Care Dental, as a courtesy we will send you a confirmation reminder and appointment reminder. We ask you call us back or that you respond with a "C" to confirm. Unconfirmed appointments may be cancelled with the need to reschedule at a later time.
- As a courtesy, please notify our office if you cannot make your appointment at least 48 hours prior to the scheduled time.
- Any changes to appointments are not accepted by text or email. Please call our office and speak to a team member to make or change an appointment.
- For patients with a history of missing or canceling appointments at the last minute, a deposit may be required to secure a future appointment and/or become same day only.
- If you arrive 10+ minutes late for your scheduled appointment, you may be asked to reschedule. This is done out of respect for our other patients with scheduled appointments. Please call ahead to let us know if you are running late, and we will do all we can to still accommodate you when our schedule permits.

DENTAL INSURANCE

- For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement on your behalf.
- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select services they will and will not cover.
- Our computer software makes an **"estimate"** of what your insurance will cover, and the balance will be your out of pocket cost. **This is only an estimate**, and it is possible that your insurance may cover less than what is estimated. If your insurance does not pay the estimated benefit in full**, you will be immediately responsible for any remaining balance**.
- Any estimated out of pocket balances, deductible, or coinsurance is **due on day of service**.
- If we do not receive payment from your insurance carrier within 60 days, **you will be responsible for payment of any balance due**.

OUT OF NETWORK INSURANCE

- Payment is **due in full on day of service**
- For patients with dental insurance that we are not in-network, we are happy to send a claim as a courtesy to your insurance company, and **they will reimburse you directly**.
- We cannot give estimates for what the insurance company will reimburse you.

FINANCIAL POLICY

- All payments are **due in full on day of service.**
- Forms of payments we accept:
  Cash, Checks, Money Orders, Credit/Debit Cards (Visa, MasterCard, Discover, American Express, and Care Credit)
- Care Credit, Cherry and Proceed Financing are companies that offer interest free payment options as well as long term interest payment options. This is a company not affiliated with Select Care Dental and we do not have any control over acceptance in this program. We will assist you in the application process as much as we possibly can.
- For any returned checks there will be a returned check fee of **$50** charged to your account.
- Patient acknowledges and agrees that **all accounts past 30 days may bear a compounding interest rate of 1.5% per month**. In the event that the patient does not pay for performed services, Select Care Dental may place patient's account with a collection agency. The patient further agrees to pay reasonable collection fees, attorney fees, and court costs incurred in collection of an overdue account.
- Patients who have had their accounts turned over to collections will no longer be considered active in the dental practice and will only be seen on a cash basis once the balance has been taken care of with the collection agency.

REPONSIBLE PARTY

- As the responsible party, in the case where any spouse and/or children are also patients at Select Care Dental, these office policies will apply to them and their accounts as well.

By signing below, I acknowledge and agree to all the above policies of Select Care Dental

Signature Date

SELECT CARE DENTAL Redmond

Permission to Disclose Health Information

We may disclose your health information to a family member, personal representative, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, **but only if you agree that we may do so**. Please list the individuals below who have your permission to share your health information:

Name	Relationship to Patient	Account or Medical or Both Access

Signature: _____Date:_____

Patient Consent to Release Dental Records

I, _____, give my consent for the office of _____ to release my dental radiographs and dental records to Dr. Jared R. Anderson and Mark T. Nuttall.

Name of Patient:

DOB:

Address:

Telephone #:

_____ _____
Patient's Signature Date

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative Name: _____

Relationship to patient: _____

Date consent sent: _____

Authorized representative of the Select Care Dental Team:_____

Please email records to Hygiene.selectcare@gmail.com
774 SW Rimrock Way Redmond, OR 97756
Phone (541) 923-7633 Fax (541) 923-8733

SELECT CARE DENTAL Redmond

X-Ray and Exam Protocol

Each patient's preventive treatment is determined by individual patient need. Patient need is determined by several different factors, such as: periodontal disease, caries risk, and existing restorations.

Exams:
Dr. Anderson and Dr. Mark standard of care requires that each patient has an examination by one of the doctors once a year OR at every other hygiene visit. Although each of our hygienists are very skilled, knowledgeable and highly qualified in dental hygiene they CAN NOT legally diagnose dental treatment.

X-Rays:
Dr. Anderson and Dr. Mark standard of care recommends that MOST patients have annual bite wing x-rays (BWX) and/or Periapical (PA) in order to assist the doctor in diagnosing decay that is not visible to the eye. BWX-rays show decay between back teeth (molar and pre-molar). PA-rays are for the front teeth or specific tooth. These BWX and PA's also show the hygienist bone levels around your teeth and will help in diagnosing the presence, severity and progression of periodontal disease.

Every 3-5 years the Select Care Dental standard of care recommends a full mouth series of x-rays or a panoramic x-ray. These films show decay the roots of teeth, bone levels, third molars (wisdom teeth) and tooth development in children. The doctors use these x-rays to diagnose decay, cysts, tumors, abscesses, periodontal disease, failing restorations and anomalies.

The dentist and dental hygienist evaluate each patient for necessary x-rays. The necessity of which x-rays are taken is determined by each patient's oral health. Not all patients fall into the above recommendations.

"The Standard of Care in Oregon requires that current radiographs are available prior to providing treatment to a patient. If a patient without a medical justification refuses to allow radiographs to be taken, even with the offer to sign a waiver, then providing treatment to that patient would violate the Standard of Care in Oregon." ~Oregon Board of Dentistry

Signature: _____Date: _____

Thank you for your continued patronage with the Select Care Dental team!

SELECT CARE DENTAL

Effective Date: March 23, 2013

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We take our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible medical care. We are dedicated to defending your right to a confidential relationship with your physician. This notice is intended to inform you of how we protect, use and disclose your information, as well as to explain your right to control these disclosures.

Your Health Information: We may use and disclose health information about you without your permission for the following purposes:

I. We may disclose your information for **treatment purposes and to coordinate your medical care.**
2. We may disclose your information **to ensure that you receive insurance benefits.**
3. We may disclose your information internally **to enhance the operation of our practice.** This includes our commitment to reviewing the quality of care we provide.
4. We may disclose your information **to comply with a limited number of legal requirements,** as outlined in this notice.

Additional information regarding each of these disclosures is provided in this notice. In any case, we will only disclose the minimum amount of information necessary for the purpose it was requested.

Our Duties

We are required by law to keep your information private. We must also provide you with this Notice and abide by its terms. We may need to revise our privacy practices from time to time. We expressly reserve the right to change the terms of our Notice of Privacy Practices and to make the new terms effective for all information covered by our Notice. If such changes occur, we will let you know about the new terms by providing a copy of the changes.

Your Privacy Rights Please note that you are entitled to very specific rights regarding the use and disclosure of your information. We have listed your rights below:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our designated contact in order to inspect and/or copy your information. If you request a copy of your information, we may charge a fee for the costs of copying, mailing or other associated supplies. You may also choose to receive a copy of your health information in electronic form.

We may deny your request to inspect and/or copy information in certain limited circumstances. If you are denied access to your health information, you can ask that the denial be reviewed. If the law requires such a review, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request and we will comply with the outcome of the review.

Right to Amend

If you believe our records contain errors, you may make a written request that they be amended. We reserve the right to review your request and can decline to amend the record. We are required to place a copy of your proposed amendment in the record, even when we do not agree to amend the record itself.

We may deny your request for an amendment if we did not create the information, unless the person or entity that created the information is no longer available to make the amendment.

Right to Request Restrictions

You have the right to request restrictions on the use and disclosure of your information. We are not required to agree to your request. If we do agree, we will comply to the best of our ability unless the information is needed to provide you with emergency treatment. To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to our designated Privacy Officer/Contact. If your restriction invalidates your insurance coverage, we may require you to execute a waiver of insurance benefits and a payment agreement.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the form Request for Restriction on Use/Disclosure of Medical Information to our designated Privacy Officer/Contact. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our designated Privacy Officer/Contact .

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations.

To obtain this list, you must submit your request in writing to our designated Privacy Officer/Contact. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what format you want the list (for example, on paper or electronically).

The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Complaints and Investigations

We have developed procedures for investigating any complaints or concerns you may have regarding our use and disclosure of your information or any other complaint you may have regarding our services. The law allows you to contact the Secretary of the Department of Health and Human Services with complaints about our use and disclosure of information.

You may also contact our on-site Privacy Officer/Contact, who is dedicated to investigating complaints regarding the use and disclosure of information in our care. We will not, and legally cannot, retaliate against you for any complaint.

Types of Use and Disclosure of Your Protected Health Information

We may disclose your information for the following purposes without your consent:

For Treatment Purposes

We may disclose information needed for the provision, coordination or management of health care and related services, including the coordination between our office and a third party, such as a consultation between medical providers or a referral from our office to another provider. Personnel in our office may share

information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other health-care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

To obtain reimbursement from your insurer, we may be required to disclose your information. This may be necessary for determining your eligibility for coverage and adjudication of claims, billing, claims management and collections activities. We may also be required to disclose your information to your insurer for review of the medical necessity, coverage, appropriateness or justification of our charges.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment. You have the right to restrict disclosures of your **PHI** to a health plan if you have paid out-of-pocket in full for the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. Healthcare operations may include:

- Quality assessment and improvement activities
- Reviewing the competence or qualifications of healthcare professionals or evaluating practitioner and provider performance
- Conducting training programs, accreditation, certification, licensing or credentialing activities
- Arranging for or conducting medical review, legal services or auditing functions, including fraud and abuse detection and compliance programs
- Managing and operating our practice, including activities such as customer service and complaint resolution

Appointment Reminders

We may contact you (via voicemail messages, postcards or letters) as a reminder that you have an appointment for your treatment or medical care at our office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you. We also may tell you about health-related products or services that may be of interest to you.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written, prior authorization. We will not sell your PHI to another organization for marketing or any other purposes.

Special Situations

We may use or disclose health information about you <u>without your permission</u> for the following purposes, subject to all applicable legal requirements and limitations:

1. **<u>To Avert a Serious Threat to Health or Safety</u>. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.**
2. **<u>Required By Law</u>. We will disclose health information about you when required to do so by federal, state or local law.**
3. **<u>Research.</u> We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission** if **the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.**
4. **<u>Organ and Tissue Donation</u>.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
5. **<u>Military, Veterans, National Security and Intelligence</u>.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
6. **<u>Workers' Compensation</u>.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
7. **<u>Public Health Risks</u>.** We may disclose health information about you for public health reason in order to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
8. **<u>Health Oversight Activities</u>.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
9. **<u>Lawsuits and Disputes</u>.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
10. **<u>Law Enforcement</u>.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
11. **<u>Coroners, Medical Examiners and Funeral Directors</u>.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.
12. **<u>Information Not Personally Identifiable</u>.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
13. **<u>Family and Friends</u>.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object.
14. **<u>Deceased Person's PHI</u>** may be disclosed by our practice to family or others involved in the person's care or payment for care, unless our practice knows the deceased preferred that certain people not receive the PHI. Disclosures are limited to the PHI directly relevant to the person's involvement.

<u>For example</u>, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

<u>Other Uses and Disclosures of Health Information</u>

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent* we may have obtained from you.

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* **in writing,** at any time.

If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization.* However, we cannot take back any uses or disclosures already made with your permission.

You have the right to be notified following a breach of your **PHI** by our practice.

<u>Complaints</u>

If **you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact: <u>Call: 541-923-7633 or Email: office.slectcare@gmail.com</u>**

Signature:_____ Date:_____