FINANCIAL & APPOINTMENT POLICIES

As outlined in our mission statement, we are committed to providing the very best care for your child. Part of the process of providing this care involves a financial relationship between you, the parent(s) and/or guardian(s) of your child, and us, the dental health care provider. In an effort to make your visit with us as comfortable as possible, we have provided for you, prior to your first visit, a description of our financial policy. Please take the time to review our financial policy below and gain an understanding of your financial obligation to your child's dental health care. If you should have any questions, please ask the front office team member.

As a condition of providing care for your child by this office, all fees must be paid at the time the care is provided. Payment for our services may be in the form of cash, check, MasterCard, Visa, American Express or Discover. We also accept CareCredit (a medical/dental credit card).

For our patients with dental insurance, we will be happy to file a claim for you if we have received all of your insurance information on the day of the appointment. On your first visit to our office, please bring your insurance card or other insurance information. You must be familiar with your insurance benefits, as any amount not covered by your insurance company is payable at the time services are rendered and these fees may include deductibles, co-payments or certain procedures not covered by your insurance policy.

As your dental insurance plan is a contract between you, your employer, and the insurance company, some carriers will not reimburse our office. In this instance, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you the reimbursement check directly.

Please understand that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. Your employer chooses your particular policy and if you are unhappy with its coverage, you should speak with your Human Resources Department. Only your employer can adjust benefits.

Your dental insurance company is required by the Colorado Insurance Commissioner to process, pay or reject all insurance claims within thirty (30) days. We file all insurance electronically, so your insurance company will receive each claim within days of the appointment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. If you have not paid your balance within 45 days a finance charge of $5 will be added to your account.

Any account balance exceeding (60) days in age may be forwarded to a collection agency and/or attorney. All costs incurred in collecting unpaid fees will be charged to your account. These fees often exceed 50% of the unpaid balance.

We will do our best to maximize the insurance benefits that you are eligible to receive. Prior to completing any large treatment plan, we will submit a pre-determination to your insurance in order to determine what your out-of-pocket portion will be, as this amount is due the day of treatment.

The parent/guardian accompanying your child to our office is responsible for payment.

Dr. Van Tassell's treatment recommendations are based upon what he believes is in your child's best interest rather than on what your insurance covers.

A $35.00 fee will be assessed for any "returned check."

We require a minimum of 24 hours notice to reschedule an appointment. A $50.00 fee may be assessed on your account for any appointment missed without adequate notice. We do not allow repeated cancellations or short-notice changes.

I have read the above financial policy and understand my financial options and obligations as described.

_____ _____

Signature of Parent/Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Name of practice

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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _____, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, 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.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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 U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Welcome

Health History Form

Pediatric Dentistry of the Rockies
Keith Van Tassell, DDS
Zach Alleman, DDS

4609 South Timberline Rd., Suite 103B
Fort Collins, CO 80528
PH:(970) 484-4104
FX: (970) 484-5245

For your convenience… **Print this form, complete all information, and bring it with you on your first visit to our office.**
The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____ (First / Last / MI)
Nickname_____ ☐ Male ☐ Female
Siblings that we treat _____
Child's Birthdate ____/____/____ Child's Age _____
Child's Home # (_____)_____
SS#_____
Child's Home Address:_____
_____ (City / State / Zip)

2. How did you find our practice?

_____
_____

3. Mother's Information

Name _____
Mother ☐ Stepmother ☐ Guardian ☐ Birthdate ____/____/____
Employer _____
Work # (_____)_____ Ext. _____
Home # (_____)_____
Cellular Phone # (_____)_____
SS # _____ DL# _____

4. Father's Information

Name _____
Father ☐ Stepfather ☐ Guardian ☐ Birthdate ____/____/____
Employer _____
Work # (_____)_____ Ext. _____
Home # (_____)_____
Cellular Phone # (_____)_____
SS # _____ DL# _____

5. Who is Accompanying the Child Today?

Name _____
Relationship_____
Do you have legal custody of this child? ☐ Yes ☐ No

6. Person Responsible for Account

Name_____
Relationship_____
Billing Address _____
_____ (City / State / Zip)
Cellular# (_____)_____
Work # (_____)_____
E-mail _____
Other Contact Information_____

7. Primary Dental Insurance

Insurance Co. Name _____
Insurance Co. Address _____
_____
Insurance Co. Phone # (_____)_____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient_____
Policy Owner's Birthdate _____/_____/_____
Social Security # _____
Policy Owner's Employer _____

8. Secondary Dental Insurance

Insurance Co. Name _____
Insurance Co. Address _____
_____
Insurance Co. Phone # (_____)_____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient_____
Policy Owner's Birthdate _____/_____/_____
Social Security # _____
Policy Owner's Employer _____

9. Dental History

Is this the child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

_____

If yes, please explain _____

_____

_____

Why did you bring the child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

YES NO ☐☐ Lip Sucking / Biting

YES NO ☐☐ Nail Biting

☐☐ Nursing / Bottle Habits

☐☐ Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? ☐ YES ☐ NO

If yes, please explain _____

_____

	YES	NO
Is the child's water fluoridated?	☐	☐
Is the child taking fluoride supplements?	☐	☐
Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)?	☐	☐
Does the child brush his/her teeth daily?	☐	☐
Floss his / her teeth daily?	☐	☐

10. Health History

Has the child ever had any of the following conditions?

YES	NO		YES	NO	
☐	☐	Abnormal Bleeding	☐	☐	Handicaps/Disabilities
☐	☐	Allergies to any Drugs	☐	☐	Hearing Impairment
☐	☐	Any Hospital Stays	☐	☐	Heart Disease/Murmur
☐	☐	Any Operations	☐	☐	Hemophilia/Blood Disorders
☐	☐	Asthma	☐	☐	Hepatitis
☐	☐	Cancer	☐	☐	HIV + / AIDS
☐	☐	Congenital Birth Defects	☐	☐	Kidney/Liver Conditions
☐	☐	Convulsions/Epilepsy	☐	☐	Rheumatic/Scarlet Fever
☐	☐	Pregnancy	☐	☐	Allergies to Latex Product
☐	☐	Tuberculosis	☐	☐	Diabetes

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking _____

_____

Please list all drugs the child is allergic to _____

_____

Child's Physician _____

Phone (_____)_____

Is the child currently under the care of a physician? YES ☐ NO ☐

Please describe the child's current physical health...

Good ☐ Fair ☐ Poor ☐

11. Authorization to Accompany Minor Child

I authorize the following individuals to bring my child in for dental treatment and check ups while I am not present.

Name_____ **Relationship to Child**_____

Name_____ **Relationship to Child**_____

Name_____ **Relationship to Child**_____

Name_____ **Relationship to Child**_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature_____ Relationship to child _____Date _____

Our office is committed to meeting or exceeding the standards of HIPPA's privacy policies and infection control mandated by OSHA the CDC, and the ADA.