SELECT CARE DENTAL

Jared R. Anderson, DDS

Welcome to Our Dental Office!

541-323-3930 SelectCareDental.com
499 SW Upper Terrace Dr., Bend, OR 97702

The Patient

Today's Date: _____

Name: _____ Preferred Name: _____ Gender: ○ Male or ○ Female

Birth Date: _____ Age: _____ SS#: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone : _____

Email Address: _____ Preferred Contact Method: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Work Number: _____

Family Members Seen Here: _____

Emergency Contact: _____ Phone: _____

How did you hear about our office? _____

Medical History

Are you currently under a physician's care? ○ Y ○ N If so, why: _____

Please list all current medications: _____

Are you pregnant? ○ Y ○ N If yes, when are you due? _____

Do you or have you had any of the following? **Please check circle.**

○ Alzheimer's Disease	○ Artificial Heart Valves	○ Emphysema	○ Hemophilia	○ Mitral Valve Prolapse
○ Anaphylaxis	○ Asthma	○ Epilepsy	○ Hepatitis	○ Psychiatric Problems
○ Anemia	○ Cancer	○ Fainting Spells	○ High/Low Blood Pressure	○ Shortness of Breath
○ Angina	○ Cold/Fever Sores	○ Glaucoma	○ Infectious Disease (STD)	○ Sinus Trouble
○ Anxiety Attacks	○ Congenital Heart Defect	○ Heart Attack	○ Kidney Problems	○ Tuberculosis
○ Artificial Bones/Joints	○ Diabetes	○ Heart Murmur	○ Lupus	○ Other _____

Do you have a latex allergy? ○ Y ○ N

Allergic to: Penicillin, Codeine, Local Injected Anesthetics. Other Allergies: _____

Tobacco use? ○ Y ○ N Have you ever had to premedicate with an antibiotic before a dental appt.? ○ Y ○ N

Surgeries? What type and when: _____

Have you ever taken bisphosphonates? ○ Y ○ N Do you have a history of Chemical/Alcohol dependency? ○ Y ○ N

Any other health concerns? _____

Preferred Pharmacy: _____ Location: _____

The information I have given today is correct to the best of my knowledge. I understand that I must inform the office of any changes in my medical status.

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Spouse or Responsible Party Information

Social Security #:_____

The following is for: ○ The patient's spouse ○ The person responsible for payment ○ Neither-not applicable

Name, First: _____ MI: _____ Last: _____ Preferred Name: _____

Title: ○ Mr. ○ Ms. ○ Mrs. ○ Other Gender: ○ Male ○ Female Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone : _____ Best time to call: _____

Address: _____ City: _____ State: _____ Zip: _____

Employment Information

The following is for: ○ The patient ○ The person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Dental Insurance

Family Status: ○ Self ○ Spouse ○ Child ○ Other

Name of Insured: Name, First: _____ MI: _____ Last: _____

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____

Insured's Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Plan Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Secondary Dental Insurance

Family Status: ○ Self ○ Spouse ○ Child ○ Other

Name of Insured: Name, First: _____ MI: _____ Last: _____

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____

Insured's Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Plan Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can gain access to this information.

Please review this notice carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on 9/22/2013, and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

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

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI 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, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. 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 obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

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

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI 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. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. 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 the additional requests. You have the right to request such an accounting in an electronic format.

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

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

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

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. 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.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us at 541-323-3930, 499 SW Upper Terrace Dr., Bend, OR 97702.

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Print Name: _____ Date: _____

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FINANCIAL OPTIONS AND AGREEMENT

Thank you for choosing us for optimal oral health care. We have found that our patients appreciate knowing exactly what to expect from us both from a philosophy aspect and a financial aspect. Therefore, we prefer to inform our patients of these before we begin any treatment.

Our Vision

Providing complete, life-long dentistry with excellence and integrity while keeping a focus on the whole person.

Financial Arrangements

We offer the following methods of payment for services provided. This will allow us to focus on our specialty, providing you with superior customer service and optimal dentistry in a comfortable environment using up-to-date materials while keeping our fees as affordable as possible.

1. **Cash, Check , Debit Card, Mastercard, Visa, Discover & American Express Accepted**
   Payment in full is due when services are performed unless financial arrangements have been made prior to treatment.

2. **Full Pay Cash Discount**
   A 5% courtesy will be given when services are paid in full a minimum of two business days prior to the appointment date.

3. **Full pay credit discount**
   A 3% courtesy will be given when services are paid in full using credit cards (except discover) a minimum of two business days prior to the appointment date.

4. **Dental Financing Plan**
   We have made arrangements with Care Credit, Lending Club and Compassionate Finance that will finance your dental work with approved credit. This will allow you to complete your dental work without delay, and have low monthly payments with interest free options also available. Application forms are available at the reception desk.

_____ initial here

Dental Insurance

FOR OUR PATIENTS WHO HAVE DENTAL BENEFITS (INSURANCE)

We ask that you realise that we don't work for an insurance company. Rather, we work 100% for our patients. We feel that insurance can be a great benefit for many patients, and can help offset the investment of getting quality dental care performed on you and your family. We want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage. Please realise that dental insurance isn't really insurance (a payment to cover the cost of a loss). It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. For example, a dentist may recommend a crown for a tooth that has extensive decay, however, the dental plan may only cover the cost of a filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling.

Most insurance companies will not cover 100% of all dental expenses. Your portion, not covered by insurance, is due at the time treatment is performed. Please understand that dental insurance is a contract between the patient and the insurance carrier, and not between the insurance carrier and the dentist. The patient is still the responsible party regarding all dental fees, regardless of dental insurance reimbursement. We will be glad to process your insurance benefit forms as a courtesy at no charge. If the insurance company has not paid their portion after 90 days of services rendered, you will need to make full payment to this office and be reimbursed when the insurance company pays.

_____ initial here

Dental Insurance Estimates

Based on the information we have from your insurance company, we will ESTIMATE your portion of dental fees and payment will be due at the time of service. If there is a balance due after your insurance company pays their portion, you will be billed for any amount unpaid. You are responsible for any charges exceeding your benefits. As a courtesy, our office will assist in making collections from the insurance company by filing the necessary forms. However, our office cannot render services based on the assumption that charges will be paid by the insurance company.

_____ initial here

Appointments, Timeliness, and Communication

Please remember that your appointments are reserved specifically for you. We are committed to seeing you on-time and request that you arrive on-time for your visits as well. We want to ensure all patients are seen when promised. **We request that at least 48 hour notice be given if an appointment needs to be rescheduled.** We prefer open and honest communication in our office, and request your permission to tell you the exact condition of your oral health and to explain the optimal way to treat it.

_____ initial here

Treatment Fee Estimates

Dental treatment fees given are based on the treatment anticipated at the initial comprehensive examination. Some teeth may have hidden decay or fractures, affected nerves or other unanticipated conditions requiring more extensive dental treatment. In situations where additional charges are involved, we will explain the reason for additional treatment needed. Our financial coordinator will discuss the additional fees and financial arrangements involved.

_____ initial here

Interest

A 1.5 % monthly interest charge (18% APR) will be applied to **ALL BALANCES OVER 30 DAYS PAST DUE**.

Accounts that are unpaid for more than 90 days may be sent to a collection agency, in which case a 40% charge on the unpaid balance will be applied to the account.

_____ initial here

Returned Checks

A $40.00 charge will be applied to all returned checks.

PLEASE FEEL FREE TO CONTACT US IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING DENTAL TREATMENT OR FINANCIAL ARRANGEMENTS.

_____ initial here

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Print Name: _____ Date: _____

PRINT at home and bring to your appointment