SHEILA HARTLE, D.D.S.
HARTLE FAMILY DENTISTRY
1685 Briargate Blvd., Suite C
Colorado Springs, CO 80920
(719)528-7016

Welcome to Hartle Family Dentistry! We are happy to have you as part of our dental family. At Hartle Family Dentistry we are committed to providing conservative and compassionate care with excellent results. We strive to treat our patients as we would want our own family and friends treated – with complete integrity, gentleness and a goal of creating lasting relationships.

When you have an appointment in our office, and treatment is recommended by Dr. Hartle, the treatment details will be discussed with you, including the fees for the treatment.

The following information will help you understand our financial policy for all recommended treatment:

- We ask for payment in full at the time the treatment is provided, if you do not have dental insurance. For patients with dental insurance, we ask for payment in full of your estimated responsibility, at the time the treatment is provided. Hartle Family Dentistry accepts VISA, MASTERCARD, DISCOVER, personal checks and cash.
- As a courtesy to you, we will help process all your dental insurance claims. We provide insurance estimates to you on the recommended treatment, **but this is not a guarantee your insurance company will pay the estimated amount.** We provide the treatment we feel is best for each patient. As your dental care provider, our relationship is with you, and not your insurance company. You will be responsible for any remaining balance after your insurance company has paid.
- After you have paid the estimated amount you are responsible for, and after we receive payment from your insurance company, we will send you an account billing statement if there is a remaining balance.

Please don't hesitate to let us know if you have any questions or concerns. Thank you!

I, _____, have read and understand Hartle Family
(Print Name)
Dentistry's financial policy.

_____ _____
Signature Date

Personal Information

Date _____

Name _____ Wishes to be called _____

Birthdate _____ Soc.Sec.# _____

❑ Male ❑ Female ❑ Minor ❑ Single ❑ Married ❑ Divorced

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Driver's License# _____ Referred by _____

Emergency Contact _____ Phone _____

Patient Email _____

Responsible Party

Who is responsible for the account? (If different from above)

Name _____ Relationship to Patient _____

Birthdate _____ Soc. Sec.# _____

Address _____ City _____ Zip _____

Employer _____ Occupation _____

Home Phone _____ Work Phone _____ Driver's Lic. # _____

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Insured's Birthdate _____ Soc. Sec.# or ID# _____

Employer _____ Occupation _____

Insurance Company _____ Group# _____ ID# _____

Ins. Co. Address _____

If you have additional insurance, please complete the following:

Name of Insured _____ Relationship to Patient _____

Insured's Birthdate _____ Soc. Sec.# or ID# _____

Employer _____ Occupation _____

Insurance Company _____ Group# _____ ID# _____

Ins. Co. Address _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer.

Payment in full at each appointment: ❑ Cash ❑ Personal Check **Credit Card:** ❑ Visa ❑ MC

❑ I wish to discuss the dental office's policy ❑ Discover

LATE CHARGES:
A late charge of 1.5% or $5.00 (which ever is greater) will be assessed monthly on all balances overdue 25 days after the monthly billing date.

Dental History

Reason for visit _____

When was your last dental visit? _____

When were your last x-rays? _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot, cold, or sweet foods?	❑	❑
3. Do you have any sores or lumps in or near your mouth?	❑	❑

4. Have you ever experienced any of the following problems in your jaw?

	YES	NO		YES	NO
a. Clicking	❑	❑	c. Difficulty in opening or closing	❑	❑
b. Pain (joint, ear, side of face)	❑	❑	d. Difficulty in chewing	❑	❑

Medical History

Are you in good health? _____ If no, explain _____

Have there been any changes in your general health within the past two years? _____ If yes, explain _____

_____

Have you been hospitalized in the past two years? _____ If yes, explain _____

Physician's name _____ Phone _____

Date of last physical exam _____

Are you now under the care of a physician? _____ If yes, explain _____

Are you taking any medicine(s) including non-prescription medicine? _____ If yes, list _____

_____

Have you had any abnormal bleeding? _____ Do you use tobacco, vaping, e-cigarettes, marijuana? _____

Are you allergic to or have you had reactions to:

	YES	NO		YES	NO
1. Local anesthetics like novocaine?	❑	❑	4. Penicillin or other antibiotics?	❑	❑
2. Sulfa Drugs?	❑	❑	5. Aspirin?	❑	❑
3. Pain Medication?	❑	❑	6. Other?	❑	❑

If yes, explain _____

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING?

	YES	NO		YES	NO
1. Rheumatic fever	❑	❑	14. Joint replacement	❑	❑
2. Heart murmur	❑	❑	15. Stomach ulcer	❑	❑
3. Heart trouble, heart attack or angina	❑	❑	16. Kidney trouble	❑	❑
4. Pacemaker	❑	❑	17. Tuberculosis	❑	❑
5. Heart surgery	❑	❑	18. Cancer	❑	❑
6. High blood pressure	❑	❑	19. Epilepsy	❑	❑
7. Hepatitis, jaundice or liver disease	❑	❑	20. Anemia	❑	❑
8. Aids or HIV infection	❑	❑	21. Blood disease	❑	❑
9. Stroke	❑	❑	22. Seizures	❑	❑
10. Asthma	❑	❑	23. Arthritis	❑	❑
11. Sinus trouble	❑	❑	24. Osteoporosis	❑	❑
12. Diabetes	❑	❑	25. Autoimmune Conditions	❑	❑
13. Thyroid problems	❑	❑	If yes, explain _____		

Do you have any disease, condition or problem not listed above you think the doctor should know about? _____

WOMEN ONLY:

Are you pregnant or think you may be pregnant? _____ Are you nursing? _____

Have you ever taken medication for osteoporosis? _____

Authorization and Release

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor 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.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

x _____

Signature of Patient, Parent or Guardian Date

HARTLE FAMILY DENTISTRY

Sheila Hartle, D.D.S.

1685 Briargate Blvd., Suite C

Colorado Springs, CO 80920

(719)528-7016

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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)

_____

_____

_____

HARTLE FAMILY DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Patient Number: _____

SECTION B: **TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations, including the following:

-sending appointment reminder postcards in the mail and through text message

-leaving voice messages on answering machines at home, cell phone voice messaging systems, and your personal voice mail at your place of employment with information concerning appointment times, dates, and procedures

-discussing appointment times, dates, procedures and billing information with the parent, spouse, or other family members as necessary or the names listed below

_____

_____

-if you have a member of your office staff that will schedule appointments for you, or accept confirmation calls for you, by listing their name on the line below you authorize this office to discuss your appointments with them.

_____

Notice **of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Sara Telephone: 719-528-7016 Address: 1685 Briargate Blvd., Colorado Springs, CO 80920

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

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STATEMENT OF PRIVACY PRACTICES

We are dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act. This includes issues relating to your treatment, payment, and our dental care operations. You may give written authorization for us to disclose your information to anyone you choose, for any purpose but it will never otherwise be given to anyone – even family members – without your written consent.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all current and former patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations and comply with the law. This may include your name, address, telephone number(s), Social Security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, the information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. This includes issues in which we reasonably believe you may be a victim of abuse, neglect, domestic violence, or other crimes. We are also obligated to provide information to law enforcement officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have a right to get copies of your healthcare information; to obtain copies in a variety of formats; and to a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can, also, notify the U.S. Department of Human Services.

We thank you for being a patient at our practice. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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Statement of Medicaid/Medicare Membership

Are you or one of your dependents currently a member of Medicaid, Health First Colorado, DentaQuest or other government sponsored medical or dental assistance program?

- ☐ YES
- ☐ NO

Are you or one of your dependents currently a member of Medicare Part A or Medicare Part C (Medicare Advantage)?

- ☐ YES
- ☐ NO

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform Hartle Family Dentistry of any changes to my Medicaid/Medicare status.

*We are **NOT** in network with Medicaid/Medicare and are **unable** to file claims to Medicaid/Medicare. *

_____

{Please Print Name}

_____

{Signature}

_____

{Date}

REQUEST FOR RECORDS RELEASE AND TRANSFER

I authorize release of all x-rays and records for patient:

_____,

from Dr. _____,

office located at _____

_____.

Records will be released to: **Sheila Hartle, D.D.S**., located at:

1685 Briargate Blvd, Suite C

Colorado Springs, CO 80920

(719)528-7016

Email: office@hartlefamilydentistry.com

_____ _____

Date Signature (Patient or Parent if Minor)