HARTLE FAMILY DENTISTRY

SHEILA HARTLE, D.D.S.

FINANCIAL POLICY

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, AMEX, 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.

- No Show appts will require pre-payment before your next appt or $75 NO SHOW fee.

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

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

Signature _____ Date _____
Patient/Parent or Guardian

HARTLE FAMILY DENTISTRY

Patient Information

Name_____ Preferred Name_____ Date of Birth_____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address_____

Phone _____ ☐ Home ☐ Cell ☐ Other Social Security Number _____

E-mail address _____

Emergency Contact Name _____ Emergency Contact Phone _____

Referred By _____

Dental Insurance Information

Name of Subscriber _____ Relationship to Patient _____

Subscribers Date of Birth _____ ID # or SSN # _____

Insurance Company _____ Employer/Occupation _____

Group Number _____ Ins Co. Address _____

If you have additional Insurance, please add below:

Name of Subscriber _____ Relationship to Patient _____

Subscribers Date of Birth _____ ID # or SSN # _____

Insurance Company _____ Employer/Occupation _____

Group Number _____ Ins Co. Address _____

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

Financial Arrangements

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

Address_____ Phone _____ ☐ Home ☐ Cell ☐ Other

- 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 dependent.

Signature _____ Date _____

Patient/Parent or Guardian

HARTLE FAMILY DENTISTRY

New Patient Medical History

Patient Name_____ Date of Birth_____

Are you in good health? ☐ YES ☐ NO If no, explain: _____

Do you have an existing illness? ☐ YES ☐ NO If yes, please explain: _____

Have you been hospitalized in the past two years or had surgery including out-patient surgery? ☐ YES ☐ NO

If yes, please explain:

_____

Are you under the care of a Primary Care Physician? ☐ YES ☐ NO Date of last physical exam: _____

Have you had any abnormal bleeding? ☐ YES ☐ NO

Do you use: ☐ Tobacco ☐ Vaping ☐ E-cigarettes ☐ Marijuana ☐ NONE

Are you taking any medications, including vitamins and herbal supplements? ☐ YES ☐ NO

If yes, please list: _____

_____

Do you have, or have had any of the following? If yes, please describe:

Yes	No		Yes	No	
☐	☐	Heart trouble, heart attack, or angina	☐	☐	Hepatitis
☐	☐	Heart surgery	☐	☐	Liver disease/Jaundice
☐	☐	Heart murmur	☐	☐	HIV/AIDS
☐	☐	Pacemaker	☐	☐	Anemia / Other Blood Disease
☐	☐	Asthma, Sinus Trouble	☐	☐	Tuberculosis
☐	☐	Rheumatic Fever	☐	☐	Epilepsy/Seizures
☐	☐	High Blood Pressure	☐	☐	Kidney Trouble
☐	☐	Stroke	☐	☐	Diabetes
☐	☐	Arthritis	☐	☐	Thyroid Problems
☐	☐	Osteoporosis			
☐	☐	Are you taking or have you ever taken medication for osteoporosis? _____			
☐	☐	Cancer --- Date : _____Type : _____			
☐	☐	Joint Replacement --- Date : _____Type : _____			
☐	☐	Auto-immune Conditions _____			
☐	☐	**Do you have any allergies?**			

o Antibiotics _____

o Local Anesthetics _____

o Other _____

☐ ☐ **Women Only**: Are you pregnant? Due Date: _____ Nursing? ☐ YES ☐ NO

Dental History

When was your last dental visit? _____ When was your last X-rays? _____

Do your gums bleed while brushing or flossing? ☐ YES ☐ NO Are you sensitive to: ☐ Hot ☐ Cold ☐ Sweet foods?

Do you have any sores or lumps in or near your mouth? ☐ YES ☐ NO

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

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.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that provided 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.

Patient/Parent/Guardian Signature _____Date _____

HARTLE FAMILY DENTISTRY

NOTICE 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.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name _____

Address _____ Phone Number _____

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.

  _____

Patient/Parent or Guardian Signature_____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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:

Karyn, Office Manager, at 719-528-7016

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

Please Print Name _____

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.

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 ☐ An emergency prevented us

☐ Other (Please Specify) _____ Initials _____

HARTLE FAMILY DENTISTRY

REQUEST FOR RECORDS RELEASE AND TRANSFER

I authorize the 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

_____ _____

Signature (Patient or Parent if Minor) Date