Mesa Ridge Dental Center
6980 Mesa Ridge Parkway
Fountain, Colorado 80817
P: [719] 392-4231/F: [719] 392-9096

HELLO! WELCOME TO OUR OFFICE!

We are happy you have chosen our practice, and thank you for allowing us the opportunity to assist you with your complete dental health needs. We look forward to meeting you, and want you to know that we are dedicated to providing you with the highest quality of dentistry and patient education.

The following outlines our office policies and should answer commonly asked questions.

APPOINTMENTS
We have reserved a specific time for the doctor to devote to your dental health. We strive to see all patients at the scheduled time. However, sometimes, due to circumstances beyond our control, the doctor may be detained. Please accept our apologies if this should happen to you, and know that we will make every effort to keep you apprised of any delay and give you the opportunity to reschedule.

MISSED APPOINTMENTS
When someone misses or changes a scheduled appointment at the last minute, it is difficult to schedule another patient for that time. Not only is this unfair to the doctor who has reserved the time to treat you, but it is also unfair to other patients who could have been seen at your scheduled time. Therefore, we ask, out of courtesy to the doctors and other patients, that you contact the office 24 hours in advance if you cannot make a scheduled appointment. Cancellations with less than 24 hours notice, or missed appointments will result in a $40.00 "Missed Appointment" charge being added to your account. While circumstances may allow for us to waive this charge, we will only do so once per account.

TREATMENT PLANNING
On your first visit to the office, the doctor and staff will conduct a complete oral evaluation to best determine the present state of your dental health. This will include a full mouth series of x-rays and periodontal probing. Probing determines periodontal pockets, which are indicative of gum disease—one of the most prevalent causes for tooth loss and other serious health conditions. Sometimes, in complex cases, there may even be a need to make diagnostic study models of your mouth. Using this combined information, the doctor will fully evaluate your dental health needs, and design a personal treatment plan to help you reach your goals for dental health and to address your aesthetic concerns. You will have ample opportunity to meet the doctor and ask about your care and his or her philosophy as it relates to you and your family.

After the doctor has explained your treatment plan to you, you will meet with a Treatment Coordinator for a confidential conference regarding your treatment. Specific questions regarding treatment choices, estimated dental benefits, payment requirements, and future appointments will be answered.

FINANCIAL ARRANGEMENTS
After you accept your treatment plan, you will receive a written ***estimate*** of the cost to you for your treatment. Although we try to be as accurate as possible, rarely can we determine the exact final cost. This is due to several factors. Our estimates are often based on incomplete or outdated information provided to us by your dental benefits plan. Additionally, sometimes the degree of damage to the teeth can be more extensive than revealed on the x-rays and/or in the oral evaluation. Once treatment is started, the doctor may have to change a procedure or method of treatment due to the condition of your teeth or bones. This may change the ultimate cost to you.

For some dental benefit programs, we are required to collect co-payments and payments in full for services rendered on the day of service. This allows us to provide services at the plan fee, and reduces our billing costs. For your convenience we accept Care Credit, Visa, MasterCard, and Discover as well as cash and personal checks. If you have any unusual circumstances, please let us know **before** any scheduled appointment, and we will have you speak with our financial department to make arrangements.

All payments and financial arrangements are subject to our Financial Policy and Patient Agreement, which we require you to read and sign prior to treatment.

CHILDREN
Our liability insurance does not permit children to be left unattended in our reception area when the parent or guardian is being treated. Therefore, children under the age of 14 must always be accompanied by a parent, legal guardian, or responsible adult. Also, we do not allow children in the treatment room while the parent is being treated. This is for your safety, the safety of the child, and the safety of our staff. Please arrange child care prior to your appointment. Generally, for your child's best interest and for sterilization and OSHA requirements, we do not allow parents in the treatment area while children are treated. Our experience has shown that children do better in treatment without the presence of their parents or guardians. We do welcome the parent's desire to meet the treating doctor and see our treatment rooms, but before the actual treatment can begin, we ask you to be seated in the reception area. Please understand that some children are better treated by a specialist, and we may need to refer a child to a specialist if we feel it would be in the child's best interest.

Parents or legal guardians must physically remain on the premises while children under 14 are being treated. This is necessary to make medical decisions or provide consent if treatment changes are needed or an emergency situation arises. Minors 15 to 18 years of age may attend dental appointments without parents or guardians if a consent form has been signed by the responsible parent **before** treatment. You can make arrangements to have this form on file for your children when you join our practice. However, we will still need a telephone number where you can be contacted during treatment should the need arise.

FOOD AND BEVERAGES
We take great pride in our state-of-the-art facility. For that reason, and for sanitation reasons, and since unfortunately accidents do happen, we ask that you not bring any food or beverages into this building. We do have a drinking fountain if you need water. We apologize for any inconvenience this may cause you.

CELL PHONES AND PAGERS
When a patient's cell phone rings or pager beeps while the patient is receiving treatment, it can be very distracting to the treating professional. Therefore, we ask that you please plan to turn off all pagers and cell phones upon entering our building.

THANK YOU again for choosing Mesa Ridge Dental Center for all your dental health needs. We look forward to a long relationship with you and your family. We are committed to providing you and your family the best possible dental care. We hope that our dedication to excellence will be demonstrated to you through the course of your treatment. If you have any questions or concerns, please feel free to call or visit our office.

PATIENT'S DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN/WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	☐	☐
DO YOU FEEL PAIN TO 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 HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐

	YES	NO
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE.	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT _____		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

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 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 PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE 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.

X _____ DATE _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS _____

_____ SIGNATURE _____ DATE _____

PATIENT'S NUMBER

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. ARE YOU IN GOOD HEALTH	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM: _____		
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____	☐	☐
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	☐	☐
8. HAVE YOU HAD ANY ABNORMAL BLEEDING	☐	☐
9. DO YOU BRUISE EASILY	☐	☐
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS	☐	☐

	YES	NO
12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX	☐	☐
13. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES	☐	☐
14. HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LEVITRA IN THE LAST 24 HOURS	☐	☐
15. DO YOU USE TOBACCO	☐	☐
16. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	☐	☐
17. ARE YOU WEARING CONTACT LENSES	☐	☐
18. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	☐	☐
19. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	☐	☐
WOMEN ONLY:		
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	☐	☐
ARE YOU NURSING	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS	☐	☐

	YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:		
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX / RUBBER	☐	☐
OTHER (PLEASE LIST) _____		
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐

	YES	NO
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
GLAUCOMA	☐	☐
NERVOUSNESS	☐	☐
TONSILLITIS	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐
EATING DISORDERS	☐	☐

PATIENT'S NUMBER

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ (FIRST / MI / LAST) DATE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

ITEM 07-6515767/27000

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER

REGISTRATION

MESA RIDGE DENTAL
6980 MESA RIDGE PARKWAY
FOUNTAIN, COLORADO 80817
[719] 392-4231

FINANCIAL POLICY AND PATIENT AGREEMENT

Thank you for choosing Mesa Ridge Dental for your dental health needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options and a clear financial policy. The following is our financial policy for you to read and sign prior to treatment at our office. (For the purpose of this Agreement, the terms "you" and "your" refer to the patient or the party responsible for the patient's care.)

Your portion of payment for dental treatment is due at the time of service. Acceptable forms of payment are cash, personal check, and money order. We also accept Visa, MasterCard, Discover (for amounts greater than $10.00), and Care Credit (certain restrictions apply). Payments not made at the time of service are considered past due when you leave the facility.

Regarding Dental Benefit Plans: As a courtesy to you, the practice will file claims with all standard benefit plans. You are responsible for making available to the practice complete and accurate information for the filing of claims, including all identification and benefit cards and supporting documents. **If the benefit plan denies benefits for any reason, or if no payment is received from the plan within 45 days of the date of service, you will then be responsible for paying the full amount of the bill immediately.** If payments are received from an Indemnity or PPO plan, they will be applied to your account. You agree to pay any remaining balance upon receipt of our statement.

If the practice has an agreement with your carrier, we will **estimate** the portion for which you are responsible at the time of treatment. Payment of the estimated amount, as well as any co-payment, will be required at the time of treatment. Adjustments to your account will be made once payment is received from your plan administrator, and you will be billed/credited accordingly. Any credits remaining on your account will be held for future services unless a refund is requested.

Regarding Medicare Dental Policies: Mesa Ridge Dental is not in network with Medicare. By signing this agreement and waiver, you are acknowledging you will be charged full fee for all services and are agreeing to continue seeing an out-of-network provider. Mesa Ridge Dental will not file claims with your Medicare Plan.

By signing this agreement:

1) You authorize the exchange of information relating to care and claims with your benefit plan(s), and authorize payments to be made directly to the practice for treatment provided to you under your dental benefit plan agreement, which are otherwise payable to you.

2) You agree special payment arrangements are <u>only</u> available with a written addendum to this document. You agree to pay a finance charge of 1.5% per month and rebilling charges of at least $15.00 per billing cycle if your account is past due. You agree to pay costs of collections, including reasonable attorney and/or administrative fees if your account remains delinquent for 90 days or more.

3) You agree to pay a $20.00 service fee for any check returned not paid, and understand if, upon proper Notice, such check is not paid in cash or certified funds in the time specified in the Notice, you may be responsible for three times the face value of the check or $100.00 whichever is greater plus costs of collections, including reasonable attorney and/or administrative fees.

4) You agree to pay a minimum $40.00 per hour of appointment time as a failed appointment fee if you miss or cancel an appointment without 24 hour notice to us.

PATIENT/RESPONSIBLE PARTY AGREEMENT:
I have read and understand this Financial Policy, and agree to the terms stated herein. Form 01/17

Patient's/Responsible Party's Signature	Responsible Party's Printed Name
Date	Patient's Name and Date of Birth

MESA RIDGE DENTAL CENTER
6980 Mesa Ridge Pkwy
Fountain, CO 80817

AVOIDING BREACHES OF CONFIDENTIALITY

If you have a telephone answering machine or voice mail system, our staff may have the opportunity to leave messages for you. These messages may contain confidential information regarding your condition or the fact that you are our patient. People other than you may hear these messages. **Please check one:**

_____Yes, the Mesa Ridge Dental Center staff may leave messages on my answering machine/voice mail at _____(telephone number)

_____Yes, the Mesa Ridge Dental Center staff may leave limited information on my answering machine/voice mail. Limitations: Doctor's name, date and time of appointment, and return telephone number.

_____No, no messages are to be left. I will take responsibility for attending my appointment and/or following up on treatment questions. Mesa Ridge Dental Center does not have to confirm my appointments by telephone. I fully understand it is my responsibility to pay any failed appointment charges if I miss my appointment.

There may be times when your spouse or an immediate family member will call to request information regarding your dental treatment, have questions regarding billing and insurance, or may be present in the office during your treatment and consultations. **Please check one:**

_____Yes, Mesa Ridge Dental Center staff may discuss my dental treatment with the people whose names are listed below:

_____

_____No do not discuss my dental treatment. with anyone other than me.

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

_____
Patient's Printed Name

_____ _____
Patient's/Legal Guardian's 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)

_____

_____

Mesa Ridge Dental Center
September 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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 23, 2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: Office Manager

Telephone: 719-392-4231, ext 110 Fax: 719-392-9096

Address: 6980 Mesa Ridge Pkwy #200, Fountain, CO 80817

E-mail: info@mesaridgedental.com

Mesa Ridge Dental Center
Acknowledgement of Receipt of Notice of Privacy Practices
April 2018

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

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

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify)

Agreement to Receive Electronic Communications

To obtain patient agreement to receive communications via text and/or email

Patient Name_____ **Date of Birth**_____

I agree that Mesa Ridge Dental may communicate with me electronically via text or email.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address and cell phone number.

I can withdraw my consent to electronic communications by calling : 719-392-4231.

Email address: (please print clearly) _____@_____.

Cell phone number _____

Patient Signature_____

Date:_____