Highlands Dental

Patient Last Name: _____
First Name: _____
Date of Birth: _____
☐Male ☐Female
If minor, parent's name: _____

Address: _____
City: _____ State: ___ Zip: _____
Cell Phone: _____
Home Phone: _____
Email Address: _____
Social Security #: _____
Drivers License #: _____

Who should we notify in case of emergency?:
_____
Phone: _____

How did you hear about Dr. Burger?
_____
_____
_____

Dental Insurance

Primary

Subscriber Name: _____
Date of Birth: _____

Employer Name: _____
Insurance Company: _____
Phone: _____

Subscriber ID or SSN #_____
Group # _____

Secondary

Subscriber Name: _____
Date of Birth: _____

Employer Name: _____
Insurance Company: _____
Phone: _____

Subscriber ID or SSN #_____
Group # _____

Consent:

I consent to the diagnostic procedures and treatment advised by Dr. Burger necessary for proper dental care.
I consent to Dr. Burger's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
I consent to the disclosure of my records (or my child's records) to those who are involved in my care (or my child's care) or payment for that care.
My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to Highlands Dental of insurance benefits otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payer.

I attest to the accuracy of the information on this page.

_____ _____
Signature Date

_____
Print Name

Patient Name _____

It is important that we know about your medical history. Many things have a direct bearing on your health. We will review the questionnaire and discuss it with you in detail. Information you give us is strictly confidential and will not be released to anyone without your written permission.

Physician's Name _____ Date of Last Physical Examination_____

In Case of Emergency, Notify_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Do you have any of the following? Please indicate with a check mark. √

Yes	No		Yes	No		Yes	No		Yes	No	
❒	❒	Heart Problems	❒	❒	M.S./M.D./Cerebral Palsy	❒	❒	Tuberculosis	❒	❒	Blood Transfusion Dates_____
❒	❒	Heart Murmur	❒	❒	Epilepsy	❒	❒	Arthritis	❒	❒	Artificial Joints
❒	❒	High Blood Pressure	❒	❒	Hemophilia	❒	❒	Asthma	❒	❒	Malignancies
❒	❒	Low Blood Pressure	❒	❒	Allergies to _____	❒	❒	Typhoid Fever	❒	❒	Sinus Problems
❒	❒	Circulatory Problems	❒	❒	Allergies to Anesthetics	❒	❒	Diabetes	❒	❒	Psychiatric Care
❒	❒	Stroke	❒	❒	Measles	❒	❒	Ulcer	❒	❒	Lupus
❒	❒	Pacemaker	❒	❒	Mumps	❒	❒	Hepatitis (circle: A B C D E)	❒	❒	Are you pregnant?
❒	❒	Bleeding Problems	❒	❒	Rheumatic Fever	❒	❒	Sexually Transmitted Disease			
❒	❒	Anemia	❒	❒	Scarlet Fever	❒	❒	Positive HIV (AIDS)			
❒	❒	Nervous System/Problems	❒	❒	Tonsillitis	❒	❒	AIDS			

Explanation of Above: _____

Medications: List medications you are taking (or within past 30 days) (Prescribed or over-the counter, i.e. Antibiotics, Birth Control, Aspirin, etc)_____

Are you now, or have you ever taken a class of drugs called Bisphosphonates (i.e. Fosemax, Boniva, Skelid, etc.)?
❒ Yes ❒ No Explain: _____

Have you had any clicking or discomfort in your jaw joints? ❒ Yes ❒ No Explain: _____

Are you currently under the care of a physician? ❒ Yes ❒ No Explain: _____

Have you been hospitalized for any reason in the past 5 years? ❒ Yes ❒ No Explain: _____

When was the last time you were at the dentist? _____ When was the last time you had a cleaning? _____

Why did you leave your last dentist? _____

Have you had any problems with previous dental treatment?
❒ Yes ❒ No Explain: _____

Signature:_____

Dentist Notes

_____

_____

_____

_____

Highlands Dental

2201 W. Wildcat Reserve Parkway Unit C-6
Highlands Ranch, CO 80129
303-220-1122
myhighlandsdental.com

General Consent

I, _____ consent to be a patient at Highlands Dental and agree to a radiographic and clinical examination. I also understand the following:

1. During the course of treatment I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canal treatment), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. I authorize Dr. Burger to prescribe and/or administer any drugs, medicaments, antibiotics, and local anesthetics necessary or appropriate in my care.
3. I will provide a thorough and complete medical history, supply a full list of my medications with dosages and consent to Dr. Burger communicating with my other medical practitioners to inquire about any aspect of my health history.
4. No guarantees can be made about treatment outcomes, restoration longevity or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
5. I will pay in full my cost of treatment or estimated insurance co-payment according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am ultimately responsible for any and all fees. Although the office will try to best estimate how my insurance company will pay, each plan is different and it is possible that insurance companies will not pay as expected or not pay at all, thereby leaving myself with a balance that will need to be paid in full.
6. If my insurance company has not paid my claim in full within 90 days of treatment I understand that I will be required to pay this balance and then I will need to seek reimbursement from my insurance company.
7. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with the dental staff.
8. I am welcome to ask questions about any aspect of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspect of my treatment that I am unsure about.

_____

Patient or Legal Guardian Signature Date

OFFICE POLICY

Payment will be expected at the time of service for all fees and estimated co-pays.

Insurance contracts: As a courtesy to you, if we have a "Participating Contract" with your insurance carrier, we will accept assignment on all covered services and bill your carrier for you. You are responsible for the co-pay, co-insurance, deductible, and for all non-covered services.

Insurance plans represent a contract between you and your insurance company. These contracts are not between this office and the insurance company. We will do our best to help you obtain benefits, but we cannot be held responsible if your carrier does not pay. Further, if a member of our staff advises you that you are fully covered or implies that you will owe nothing, it is your responsibility to contact your insurance company for verification. Therefore, it is your responsibility to make certain your carrier makes prompt payment, and to handle any disputes that may arise. **If your insurance carrier has not paid your claim within 90 days of treatment, you will be responsible for any unpaid balance. You will also be responsible for following up on the outstanding claim for reimbursement.**

If your insurance is found to not be in effect on the date dental services are provided you will be responsible for the full balance. A finance charge of 18% APR (1.5% a month) will be added to the total balance on all accounts over 60 days past due.

Third party financing may be available for patients requiring extensive treatment through CareCredit. This type of financing must be approved in advance, and is only valid for treatment amounts over $1,000.

If at any time you have questions regarding any treatment, fees, or services, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding, to rectify an injustice, or to preserve a friendship.

Missed appointments: Our policy is to charge for missed appointments unless a cancellation is received at least 48 hours in advance. **The charge is $75 per hour of the scheduled time.**

Children in the office: Please make arrangements for your non-scheduled children prior to your visit. Children should not be left unattended in the reception area. All children 17 years of age and under scheduled for treatment **MUST** have a parent or legal guardian present in the office during their appointment.

Cell Phones: We request that all cell phones be turned off or set to silent mode during your appointment.

Family/Friends: For the safety and comfort of our patients and employees, no friends or family members will be permitted to accompany patients in the treatment area during the appointment. Any patients with special needs can make necessary arrangement with the office manager prior to your appointment.

We reserve the right to dismiss any patient from our practice for inappropriate behavior in our office or on the phone.

I acknowledge that I am responsible to pay all charges for treatment administered by Highlands Dental as outlined above and that if my account is placed with a collections agency for non-payment that I will be responsible for all collections costs, including court costs and associated attorney fees.

I have read the policies and agree with the terms outlined above.

Signature: _____

Printed Name: _____ Date: _____

Highlands Dental Financial Policy

Please initial each as your acknowledgment of the following policies:

Personal Information:
_____ I will inform Highlands Dental of any changes in my address, phone number(s), email addresses, and insurance information.

Insurance:
_____ Complete and accurate and/or updated insurance information must be provided at every visit (ie: current insurance card). Highlands Dental reserves the right to deny service, reschedule, or make self-pay any appointment at any time if this information is not present and verifiable at the time treatment is administered.

_____ By signing below I authorize Highlands Dental to file claims with my insurance carrier and assign payment of dental benefits to Highlands Dental. I authorize the release of any and all dental records and information necessary to process any claim generated by a service I or my dependent(s) receive. It is my responsibility to be familiar with my own insurance policy so that I am aware of what services are covered or non-covered and any frequency limitations of my policy. I will be responsible for payment of dental services provided if my insurance company denies payment.

_____ If my insurance company has not paid my claim in full within 90 days of treatment I understand that I will be required to pay this balance and then I will need to seek reimbursement from my insurance company.

_____ All co-pays are due at the time of service or my appointment will be rescheduled. Any previous balance due at any appointment will be collected at check-in or I may be asked to reschedule until payment is made. Highlands Dental cannot waive or change co-pays or balances due as per my agreement/contract with my insurance carrier.

Non-Insured/Self Pay:
_____ Payment in full is due at the time of my appointment. Highlands Dental offers a 5% cash discount for all professional services.

Account Balances:
_____ Payment is due on the day services are rendered. We accept cash, check, Visa, MasterCard, and Discover.

_____ There will be a $10.00 billing charge assessed for every 30 days the account is past due. Should my account become delinquent, Highlands Dental may deny services. If my non-paid account is sent to our outside collection agency, the undersigned Responsible Party agrees to pay all costs associated with collection, including collection agency and attorney's fees. Furthermore, I and my family members will be terminated from our practice due to non-payment.

_____ There will be a $25.00 fee for any returned check. Cash and credit cards will only be accepted for future payments.

_____ My dental records can be sent to another office digitally at no charge to me. Alternately, hard copies can be scanned and sent for a fee: pages 1-10: $16.50, pages 11-40: $0.75/page, pages 41+: $0.50/page.

My signature below indicates that I have read and agree to the above Financial Policy and terms. I further agree that a photocopy or digital image of these agreements shall be as valid as the original.

(Parent or Guardian must sign for patients under 18 years of age.)

Patient:_____ Guardian/Guarantor:_____

Relationship to Patient:_____

Signature:_____ Date:_____

Cancellation/Missed Appointment Policy

Our goal at Highlands Dental is to provide quality dental care in a timely manner. In order to do so we have implemented an appointment/cancellation policy. This policy enables us to better utilize appointments for our patients in need of dental care.

Cancellation of an Appointment:

In order to be respectful of the needs of our patients, please be courteous and call Highlands Dental if you are unable to attend your appointment. This time will be reallocated to someone who is in need of treatment that day. If it is necessary to cancel your scheduled appointment, we require that you call **at least 48 hours in advance during our normal business hours Mon. - Thur. From 8:00 am to 5:00 pm. We cannot accept cancellations via voicemail.** For example, if you have an appointment on Monday, you must call us at least by the previous Thursday to cancel your appointment. We cannot cancel your appointment over the weekend while our office is closed. Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care. Late cancellations will be considered a "no-show".

No-show Policy:

A "no-show" is either arriving more than 15 minutes late for a scheduled appointment or a missed appointment without 48 hours notice. "No-shows" inconvenience other patients who may need access to care in timely manner. **A failure to present at the time of a scheduled appointment without adequate notice will be recorded in the patient's chart as a "no-show" and a $75.00 per hour appointment time missed will be assessed and must be paid prior to your next appointment.** Any further "no-show" appointments may result in the termination of the patient from the practice.

We may provide a courtesy appointment reminder, however, you are responsible for keeping the appointments that you make. How do you wish we contact you for appointment reminders?

- ☐ Text _____ phone number
- ☐ Phone Call _____ phone number
- ☐ Email _____ email address

I have read the above policy completely. I agree to all of the terms and understand that if I violate this policy, it may result in the termination of my doctor/patient relationship.

_____ _____

Patient Signature Date

Highlands Dental

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I have received a copy of the Notice of Privacy Practices for Highlands Dental.

_____
Print Name

_____ _____
Signature of Patient (or personal representative) Date

If there is anyone that you would like to designate to be allowed to receive communication about your dental treatment please enter their name below and sign. If not, please leave this section blank.

I hereby designate the following individuals to receive communications from Highlands Dental that may include dental/medical information about me.

I authorize Highlands Dental to leave voice mail messages concerning my health information (i.e. proposed treatment, appointment instructions, etc.)

Their Name: _____

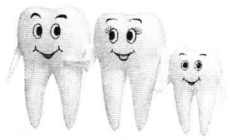
Their Phone Number: _____

_____ _____
My Signature Date

If this acknowledgment is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____



Highlands Dental
2201 W. Wildcat Reserve Parkway Unit C-6
Highlands Ranch, CO 80129

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you may gain 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. The notice took effect on April 14, 2003 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 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 policy, 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 your 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 healthcare information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your healthcare 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 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 to help with your healthcare or with payments 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 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 disclosure. 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, e-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 of 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 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 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 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 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 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).

Disclosure Accounting:

You have the right to receive a list of instances in which we or our business associate disclosed your health information for purposes, other than treatment, payment, healthcare operation and certain other activities, for the last 6 years, but not before April 14, 2013. 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.

Restrictions:

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 commute with you about your health information by alternative means or location. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory 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, pleas 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 amend or restrict the use or disclosure of your health information or to have as communicate with you by alternative means or at alternative locations. You may complain you 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 fire 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 tile a complaint with us or with the U.S. Department of Health and Human Services.

Telephone: 303-220-1122
Fax: 303-220-1044
Address: 2201 W. Wildcat Reserve Parkway, Unit C-6 Highlands Ranch, CO, 80129