



WELCOME TO IDAHO PERIO
Center for Dental Implants & Laser Periodontal Therapy

Dear Patient,

Thank you for choosing Idaho Perio Center for Dental Implants & Laser Periodontal Therapy for your periodontal/dental surgical needs. We have prepared this packet of information and forms in order to help make your first visit an efficient, productive, and pleasant experience. To prepare for your first appointment, we ask that you complete the attached paperwork and **return it in the self-addressed envelope enclosed prior to your appointment.**

- Patient Registration Form (Enclosed);
- Patient Medical History Form (Enclosed);
- Authorization to Release Healthcare Information (Enclosed) (This authorizes your general dentist/physician to send us x-rays, chart notes, etc.) (Enclosed);
- A Message About Your Insurance (Enclosed);
- AutoRemind (how you prefer we contact you for appointment confirmation) (Enclosed)

Idaho Perio Center for Dental Implants & Laser Periodontal Therapy & Your Insurance

Dr. Hansen & Dr. Townsend are certified specialists who have received extensive training in the area of periodontics and dental implants. The fees for the services we provide are established based upon skills, training, and time required by Dr. Hansen & Dr. Townsend to complete a consultation and/or procedure. You may expect the charges for your first appointment to be:
New patient consultations: from \$94 - \$218 depending on the need for dental radiographs for a diagnosis.

We expect the initial exam will go as follows: paperwork; introductions; exam; diagnosis; treatment options discussion; treatment cost; and scheduling. **This process generally takes between 60 and 90 minutes. Please arrange your schedule and the schedule of any others who may need to be present for the time we have reserved for your appointment.** Any questions concerning initial exam cost or process, please contact our front office staff at 208-377-2777.

We do require confirmation for all scheduled appointments.

Submission of Insurance Claims

*This office accepts most dental insurance companies; however, we are **NOT** in network with any.* **Your dental insurance plan may require you to elect an in-network provider to maximize your benefits. As a courtesy to our patients our office will file any dental insurance claims for you. In special circumstances your insurance may send you the benefit check. Any payments paid directly to you must be used to pay any outstanding balance on your account at Idaho Perio. Our office accepts cash, checks, all major credit cards and care credit.**

To assist our billing staff in submitting your insurance claim to both primary and secondary insurance carrier, please ensure all information is correct.

Our insurance policies;

- Your insurance policy is a contract between you and your insurance company; we are not party to that contract.
- **ALL** dental insurances will only supply you with an **ESTIMATE** of your out of pocket expense. A written preauthorization is likely going to be more accurate than a verbal estimate.
- Insurance payments that you receive directly must be forwarded to Idaho Perio Center for Dental Implants & Laser Periodontal Therapy.

Your Involvement

Idaho Perio Center for Dental Implants & Laser Periodontal Therapy will work closely with you to obtain the maximum benefits from your insurance company. While we make every effort to help patients receive their insurance benefits, insurance companies are often more responsive to their customers, the patients. To improve the payment process, our office may ask you to contact your insurance companies. The more you are involved in this process, the less likely there will be any surprises with your insurance company.

Our Commitment

Idaho Perio Center for Dental Implants & Laser Periodontal Therapy is committed to providing quality dental care to all those in need of our service. You are welcome to contact our office with your questions and concerns.

IF YOU BRING YOUR COMPLETED PAPERWORK WITH YOU, PLEASE CHECK IN 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME TO ALLOW OUR OFFICE TIME TO COMPLETE THE ADMINISTRATIVE PORTION OF YOUR APPOINTMENT AND HAVE YOUR CHART READY FOR THE APPOINTMENT.

Sincerely,

Jace Hansen, DMD, MS
Brad Townsend, DDS, MS



PATIENT REGISTRATION

Full Name: _____ Date of Birth: _____

Address: _____ Soc Sec #: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Email Address: _____ Cell phone: _____

Employed By: _____ Occupation: _____

Parent/Spouse Name: _____ Soc. Sec. # _____

Employed By: _____ Occupation: _____

INSURANCE INFORMATION

Primary Dental Insurance Co: _____ Subscriber #: _____

Primary Insured's name: _____ Group #: _____

Second Dental Insurance Co: _____ Subscriber #: _____

Second Insured's name: _____ Group #: _____

CONTACT /REFERRAL INFORMATION

Your Dentist: _____ How Long? _____

Physician: _____ City: _____ How Long? _____

Emergency Contact: _____ Telephone: _____

Whom may we thank for referring you to our office? _____

We will be happy to assist you with filing claims for pre-determinations and for insurance benefits. However, you must realize that we render services to the individual, not the insurance companies. You are responsible for the payment of your account. We cannot accept responsibility for collecting insurance claims or for negotiating a disputed claim, but we will provide what assistance we can.



HEALTH HISTORY FORM

Name: _____ Date: _____

PLEASE DESCRIBE FULLY ANY YES ANSWERS:

Date of last physical examination: _____ Purpose of exam: _____

Finding: _____

Are you being treated for anything currently: (circle one) Yes No
If yes, for what? _____

DURING THE PAST 12 MONTHS, HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS? (If yes, please circle)

- | | |
|--------------------------------------|--|
| Antibiotics | Anticoagulants |
| Medications for high blood pressure | Tranquilizers |
| Insulin, Orinase or similar drug | Aspirin |
| Digitalis or drugs for heart trouble | Nitroglycerin |
| Cortisone (Steroids) | Pain medications |
| Herbal remedies | Fosamax or similar drug for Osteoporosis |
| Other medications: _____ | |

WHAT MEDICATIONS AND DOSAGES ARE YOU CURRENTLY TAKING?

ARE YOU ALLERGIC TO OR HAD ANY UNUSUAL REACTIONS TO ANY OF THE FOLLOWING MEDICATIONS? (If yes, please circle)

- | | |
|---------------------------------|--------------------------|
| Local anesthetics ("Novocaine") | Aspirin |
| Penicillin | Sulfa |
| Tetracycline | Codeine |
| Adhesives | Morphine |
| Barbiturates, sedatives | Other pain medications |
| Anti-inflammatory meds | Latex or rubber products |
| Other antibiotics _____ | Other medications: _____ |

Woman Only

Are you taking contraceptives or hormones: Yes No
Are you pregnant or breast feeding: Yes No
expected delivery date: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Pain in your chest upon exertion:	Yes	No
Abnormal bleeding after surgery or trauma:	Yes	No
Been tested or diagnosed with diabetes:	Yes	No
If so, when and what was your most recent A1C: _____		
Any of your family members been diagnosed with diabetes:	Yes	No
If so, who: _____		
Used combination Phen-fen:	Yes	No
Pain in your teeth or jaw joints:	Yes	No
Clinching or grinding your teeth:	Yes	No
Previous periodontal treatment or diagnosis:	Yes	No
If so, what: _____		
Use tobacco in any form:	Yes	No
If so, what form: _____		
Are you interested in quitting?	Yes	No

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR CURRENTLY HAVE:

Angina Pectoris	Asthma	Nervousness
Artificial Heart Valve	Kidney Trouble	Glaucoma
Artificial Joint	Arthritis	Vertigo
Congenital Heart Disease	Thyroid Disease	Psychiatric Treatment
Heart Failure	Hemophilia	H.I.V. Positive/AIDS
Heart Murmur	Emphysema	Ulcers
Heart disease or Attack	Allergies or Hives	Fainting/Dizzy Spells
Pacemaker/Defibrillator	Osteoporosis	Cold or Canker Sores
Radiation Treatment for Cancer	Liver Disease	Hepatitis
Rheumatic Fever	Tuberculosis	Alcohol/Drug Addiction
Stroke	Epilepsy/Seizures	High Blood Pressure

Signature: _____

Date: _____

Periodontal disease is caused by a combination of complex factors and the above asked questions are designed to help us identify them. The success of therapy is dependant upon this. Therefore, although some of the questions may seem unrelated to your periodontal condition they are all associated with proper management of your oral health, and all answers are kept confidential. If there is any additional information you feel we should know please list it below.



A Message About Your Insurance

It is very important to us that you understand our office policy regarding insurance.

Although we are happy to file your insurance claim for you, please understand that we are no way affiliated with your insurance company. As there are hundreds of insurance companies across the United States, and there are thousands of different plans insurance companies offer. Your plan and what coverage you have is between you and your insurance company.

We will do our very best to file your insurance claim and provide the necessary information asked for by your insurance company.

We cannot be held responsible for claims not paid by your insurance. Any claim not satisfied by your insurance company becomes your sole responsibility.

If you desire a "Pre-Authorization" from your insurance for your upcoming procedure, if time allows before scheduling. This usually takes 4 to 6 weeks to be returned to our office.

If you have any concerns or questions regarding just what or how much of your procedure will be paid by your insurance plan, please call your insurance company.

Again, we are happy to file your claim for you as a courtesy to you our valued patient.

We will try to give you an accurate estimate regarding your portion. However, there can be unforeseen requirements by your insurance company.

Although we cannot be held responsible for the coverage of your insurance plan, we will do all that is in our power to help you get the best outcome.

If you have any questions please feel free to ask our office staff.

Signature _____ **Date** _____

Print Name _____



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.
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. This Notice takes effect 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 applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that 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 a new notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 uses or disclosures permitted by your authorization while it was in effect. Unless you give us a 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversights, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation law.

PATIENT RIGHTS

Access: You have the right to look at 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 the 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 request access by sending us a letter to the address at the end of the notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying cost, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may-but are not required to-prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost base fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: 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). Any agreement we may make to a request for addition restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health was incorrect, or
- we should communicate with you by alternative means or at alternative location,

you may contact us using the information listed below. 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.

Contact Officer: Jace Hansen
Telephone: (208)377-2777
E-mail: idahoperio@gmail.com
Address: 6019 N Eagle Rd Boise ID 83713

Fax: (208)377-3075

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to the Patient;

We are required by law to provide you with a summary of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement if you wish.

By signing below, I acknowledge that I have received a copy if Idaho Perio's Notice of Privacy Practices.

Name (please print)

Signature

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you would like to authorize our office to discuss your care with. Your PHI maybe disclosed to the individual(s) listed below until you notify us in writing otherwise.

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices summary but it could not be obtained because:

- The patient refused to sign document.
- Due to an emergency situation it was not possible to obtain acknowledgement.
- We weren't able to communicate with the patient.
- Other (please provide specific details)

Employee Signature

Date



Automated Appointment Reminders

Dear Patient,

We would like to invite you to sign up for our automated reminder system, named AutoRemind™. This system allows us to remind you of your appointments in the manner that is best suited to your needs.

AutoRemind™ can send you both appointment reminders and confirmation requests via text message, voice calls and emails. By utilizing this system, it will help you remember your appointments with ease.

Please fill out this registration form for AutoRemind™ and we will implement your request. Please note that if we do not receive this registration back before your initial consultation/evaluation we will not be able to use this program to remind you of your appointment.

Name:	
Preferred telephone:	
Preferred mobile phone:	
Email address:	

Preferred reminder method – Please select from the following reminder options:

- Voice message
- Email
- Text message

Boise Office:
6019 N. Eagle Rd. · Boise, ID 83713
208-377-2777 · Fax 208-377-3075

