Lori M Trembath DDS, PC
Family Dentistry

Request for Access

Privacy Official Name: Lori Trembath, DDS Telephone: 303-457-3046

Patient's Name (print):_____

Date of Birth:_____(for identification purposes)

Describe the records you wish to access and the approximate dates of the records:_____
_____
_____

What would you like for us to do for you?

- ☐ I wish to see the requested records.
- ☐ I wish to get a copy of the requested records.
- ☐ I wish to see and get a copy of the requested records.
- ☐ If the requested records are in an electronic designated record set, I wish an electronic copy of the requested records the following form and format, if readily producible:_____

  If you would like the information emailed, enter the email address here (PLEASE PRINT VERY CLEARLY!): _____@_____

  We do not recommend sending patient information in an unencrypted email because third parties may be able to access the email.

- ☐ I want you to prepare a summary of the requested records and I agree in advance to pay a fee in the amount of $15.
- ☐ I want you to prepare an explanation of the records that I saw or got a copy of, and I agree in advance to pay a fee in the amount of $20.

12774 COLORADO BLVD. #171 • THORTON, CO • 80241
PHONE: 303-457-3046 • FAX: 303-457-9982
www.trembathdentistry.com

☐ I want you to send the copy of the requested records to:

Name: _____

Address: _____

Fees
Our practice charges a reasonable, cost-based fee to for copies of patient information, and for postage to mail records if requested.

Questions?
Please contact our privacy official listed at the top of this page if you have any questions about your request to inspect or copy records.

If the request is by a patient:

Patient Signature:_____ Date:_____

If the request is by a patient's personal representative:

Print the Name of the Personal Representative:_____

Relationship to the Patient:_____

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of Personal Representative:_____
Date:_____

For dental office use only:

- ☐ Request for access denied (attach written denial).
- ☐ Request for access approved.

If approved, describe below when and how access was provided. If an electronic copy was provided, describe the form and format of the electronic copy.

_____

LORI TREMBATH, D.D.S. PC
FAMILY DENTISTRY

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 canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography. Some of the procedures may be performed by a dental profession other than the dentist including a dental assistant or dental hygienist that have been trained to perform certain tasks and is allowable by Colorado law.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Most dental procedures require the use of dental anesthetic or numbing to complete the procedure. I understand that there are risks involved in using anesthetic which includes permanent or temporary loss of feeling and or muscle control from nerve damage, pain from injection site including muscle tightness or even muscle damage that may or may not go back to the normal, allergic reaction, and any other side effects.

Print Name: _____

Signature: _____

Date: _____

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Family Dentistry

NEW PATIENT REGISTRATION FORM

Patient Information

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Address: _____ Address (Second Line): _____

City: _____ State/Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ Ext: ____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ SSN: _____ Drivers License: _____

Email: _____ I would like to receive correspondences via email: ☐ Yes ☐ No

Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Retired ☐ Other

Student Status: ☐ Full Time ☐ Part Time ☐ Not Applicable

Referred By: _____ Previous Dentist: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: (____) _____

When discussing your dental health, how do you prefer to be communicated with? Do you like a lot of details?

_____

Responsible Party (If someone other than patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address (Second Line): _____

City: _____ State/Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ Ext: ____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ SSN: _____ Drivers License: _____

Email: _____ I would like to receive correspondences via email: ☐ Yes ☐ No

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: _____ Insured Birth Date: _____

Employer: _____ Insurance Co.: _____

Address: _____ Address: _____

Address (Second Line): _____ Address (Second Line): _____

City, State/ Zip: _____ City, State/ Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: _____ Insured Birth Date: _____

Employer: _____ Insurance Co.: _____

Address: _____ Address: _____

Address (Second Line): _____ Address (Second Line): _____

City, State/ Zip: _____ City, State/ Zip: _____

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MEDICAL HISTORY FORM

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 you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes ☐ No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes, please explain: _____
Do you take, or have taken, Phen-Fen or Redux?	☐ Yes ☐ No	_____
Are you on a special diet?	☐ Yes ☐ No	
Do you use tobacco?	☐ Yes ☐ No	
Do you use controlled substances?	☐ Yes ☐ No	

Women

Are you pregnant/ trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/ HIV Positive	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Fainting Spells/ Dizziness	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Arhtirits/ Gout	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Artifical Joint	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Attack/ Failure	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Heart Pace Maker	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Heart Trouble/ Disease	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Stomach/ Intestinal Disease	☐ Yes ☐ No
Cold Sores/ Fever Blisters	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Congentital Heart Disorder	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Easily Winded	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Veneral Disease	☐ Yes ☐ No
Epilepsy or Seizures	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments and Signature

_____

_____

_____

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

Lori M Trembath DDS, PC

Family Dentistry

Notice of Privacy Practices
Effective: 9/23/2013

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.

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.

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 contact 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: Dr. Lori Trembath

Telephone: 303-457-3046

Address: 12774 Colorado Blvd #171, Thornton, CO 80241

LORI TREMBATH, D.D.S. PC
FAMILY DENTISTRY

In an effort to maintain treatment fees at a minimum while maintaining a high level of professional care, we have established the following financial policy for our office. Please feel free to discuss our fees with us at any time. Before any dental treatment begins, the patient and/or responsible party will receive a consultation regarding treatment plan and cost.

We require payment in full for the portion, not covered by dental insurance, of dental services to be rendered. For procedures that take multiple appointments to complete, payment may be split up over the number of appointments required. Any other financial arrangements shall be made only at the finance manager and/or doctor's discretion. We accept cash, checks, Amex Visa, MasterCard, Discover, and upon request, we can also provide information regarding financial companies to help assist with the cost of your dental procedures such as Care Credit.

As a **courtesy** to our patients with insurance, we will file your insurance claim, allowing you to pay only your deductible and/or **estimated** co-payment as services are rendered. Please remember that the contract is between you and your insurance company and your total balance in our office is always your responsibility. Please note that we allow 60 days for the dental claim to be paid. **We make every effort to give you an accurate estimate of what your portion of our fees will be, based on the information provided to us.** However, we have no way to guarantee the actual terms of your policy. If for any reason there is a balance remaining after your insurance company's payment, you will be sent the statement, and are responsible for any remaining balance. Any dispute regarding reimbursement or the amount of reimbursement is between you and your insurance carrier. **By agreeing to this policy you agree to all such conditions.**

We schedule our appointments to provide each patient with our undivided attention. In order to accomplish this, please be advised that you will be charged for cancellations with less than 24 hours notice at the rate of $50.00 for examination/hygiene appointments and $75.00 for dental procedures appointments. Also, note that any type of deposits and/or payments towards the cosmetic cases will not be refunded. Should the patient change their mind for

whatever reason during treatment, the patient will be responsible for all costs incurred including **lab fees and related costs.**

Collections

***** A charge will be added to your account for any returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on this account. This includes all attorney fees, collection fees, interest, and late fees.

An account with an unpaid balance past 60 days will be sent to a collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt from the last date of services, such as attorney fees, court fees and any other fees associated with the collection of your debt

Original records including radiographs are the property of this office. If you desire, we will provide you with a copy of your record or radiographs for a nominal duplication fee of $25.

We appreciate your confidence in choosing our practice. Please do not hesitate to inquire with a staff member should you have any questions regarding this policy.

I have read, understood, and agree to the Office Financial Policy stated above.

Signature: _____ Date:_____

LORI TREMBATH, D.D.S. PC
FAMILY DENTISTRY

Collections

I agree to pay any dental bill I incure when it is due. If my account is sent to collections, I agree to pay all costs to collect my bill including collection agency costs, attorney's fees and court costs.

Date: _____ Sign:_____ Print Name:_____

I agree that my credit card maybe charged to pay my account if it is more than 60 days overdue.

- ○ MC
- ○ Visa
- ○ Discover

Credit Card #_____

Expiration Date:_____ Zip Code_____ CVV_____

Date:_____ Sign:_____

Print Name:_____

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