ELEVATED
FAMILY DENTISTRY

Patient Information:

Patient Name:_____	**Responsible Party:**
Home Address:_____	Name: _____
(City, State, Zip)_____	Address: _____
Primary Phone: _____	(City, State, Zip)_____
Secondary Phone: _____	DOB:_____ Relation to Patient:_____
E-mail address: _____	Employer: _____
Date of Birth:_____ ( ) Male ( )Female	Primary Phone:_____
Social Security #: _____	Secondary Phone: _____
( ) Married ( ) Single ( ) Child	

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

In case of emergency, Please Contact: _____ Phone: _____ Relation:_____

Primary Dental Insurance: (Please provide us with card)

Insured's Name:_____ Insurance Policy ID: _____

Insured's SSN:_____ Group #:_____

Insureds DOB: _____ Phone Number:_____

Insurance Company Name & Address: _____ Employer:_____

_____

Dental History:

Reason for your visit today: _____

If you could change one thing about your smile, what would it be? _____

Are you interested in a simple and inexpensive way to whiten your teeth? _____

Are you interested in avoiding bad breath? _____ *Ask our hygienist about our Fresh Breath kits and Twice as Nice program!*

Name and city of Previous Dentist: _____ Approximate date of last visit: _____

Health History

1. Are you in good health? _____
2. Has there been any change in your health within the past year? _____
3. Are you now under the care of a physician? _____ Name: _____
4. Have you had any serious illness, operation, or been hospitalized in the past 5 years? _____
5. Are you taking any medications including non-prescription medications? (list medications):

   _____
6. Do you have, or have you had any of, the following:
   a. Damaged heart valves or artificial heart valves, including a heart murmur _____
   b. Cardiovascular disease (heart trouble, heart attack, angina, high blood pressure) _____
   c. Inborn heart defects _____
   d. Pacemaker_____
   e. Have you ever taken Phen-Fen? If so, have you been diagnosed with heart trouble? _____

   Please check all that apply:

- ☐ AIDS/ HIV
- ☐ Allergies
- ☐ Blood disorder such as anemia
- ☐ Arthritis or painful, swollen joint
- ☐ Artificial joints (Premed? _____)
- ☐ Asthma
- ☐ Abnormal bleeding
- ☐ Blood transfusion
- ☐ Cancer
- ☐ Codeine Allergy
- ☐ Diabetes
- ☐ Respiratory problems, emphysema
- ☐ Epilepsy, neurological disease
- ☐ Epinephrine Reaction
- ☐ Fainting spells or seizures
- ☐ Fibromyalgia
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Hepatitis, jaundice, or liver disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Mental health
- ☐ Immune system problems
- ☐ Jaundice
- ☐ Kidney Trouble
- ☐ Latex Allergy (we're a latex-free office)
- ☐ Liver Disease
- ☐ Lupus
- ☐ Persistent diarrhea or weight loss
- ☐ Persistent or Bloody cough
- ☐ Persistent swollen glands
- ☐ Pregnancy ( ) Past or Due Date:_____
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sinus trouble
- ☐ Stomach Ulcer or Hyperacidity
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Sulfa Allergy
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Other:_____

7. Are you allergic or have you ever had a reaction to: ( ) Local Anisthetics ( )Penicillin/Antibiotics ( ) Asprin ( ) Barbituates or other sedatives ( ) Iodine Allergy ( ) Other: _____
8. Do you have any disease, condition, or problem not listed above that you think I should be aware of?

   _____
9. Have you ever had any serious trouble associated with any previous dental treatment?_____
10. Are you wearing contact lenses? _____ 11b.Are you wearing removable dental appliances? _____
11. Have you ever used tobacco of any type? _____ 12b. Do you use alcoholic beverges? _____

WOMEN:

Are you pregnant? _____
Due Date: _____
Are you nursing? _____
Are you taking Birth Control Pills? _____
Have you ever taken Fosamax, Boniva, or Actonel for prevention of osteoporosis? _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to the best of my knowledge. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____Date_____

Financial Policy

We feel like our job is to provide you with excellent dentistry. We want you to be able to have a healthy mouth as quickly as possible. We have created the following options to assist you:

Option 1: Cash Pay: Receive a 5% discount on pay-in-full cash payments

Option 2: In-House Dental Benefit Plan (exclusive to the office of Dr. Garon Larsen): receive a 10-15% discount on dental services. (Excluding orthodontics) **Payment is due in full at time of service in order to qualify for discount.**

Option 3: Payment Arrangements: For procedures where your portion is over $1,000, Interest-free payment arrangements will be accepted. Half the estimated amount is due at the first visit, and the remaining balance will be split into up to 3 separate payments, debited automatically on either the 5th or the 20th of each month. Should the agreement not be upheld, late penalties and interest may be applied.

Option 4: CareCredit: This is a line of credit specially designed for medical and dental expenses. Anyone can apply for this on-line at www.carecredit.com. There is no application fee and no annual fee. This is a 6-12 month, no-interest payment plan. If you choose not to pay off the account within the 6-12 months, CareCredit automatically converts into a line of credit, which is paid off in monthly installments with interest accrued from the date the account was opened. CareCredit settles your account with us, and everything going forward is between you and CareCredit.

We accept Cash, Visa, MC, Discover, AMEX, Cashier's checks, and CareCredit. We accept personal checks on established accounts only.

I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. I understand that Dr. Larsen may not be a participating dentist in a discounted insurance plan, and that I am responsible for all charges not paid by the insurance company. I agree to pay a finance charge of 1.5% per month (18% APR) on the unpaid balance after 90 days and collection costs and/or a reasonable attorneys fee (up to 40% of principal amount owing, if any delinquent balance is placed with an agency or attorney for collection or suit.

Payment for services is due at the time services are rendered unless prior arrangements have been made. Checks that are returned to our office from your financial institution are subject to a $25.00 returned check fee. This fee covers the processing fees that are charged to our office.

We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at any time to discuss any concerns you may have. Our Financial Coordinator, Jessica, can be reached by voice or text, at 801-756-4440, or financial@elevatedfamilydentistry.com .

Thank you for understanding our Financial Policy.

Patient (or legal guardian) Signature:_____ Date: _____

Consent to treat and HIPPA

I authorize Dr. Garon E. Larsen and/or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor for which I have responsibility, including arrangement and or administration of any sedative (including nitrous oxide) analgesic, therapeutic, and/or other pharmaceutical agents. Including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include, but are not limited to, bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness and muscle soreness. I understand that occasionally needles break and may require surgical retrieval. I understand that as part of dental treatment, items including but not limited to, crowns, small dental instruments, drill components, etc. may be aspirated or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital, and may, in rare cases, require Bronchoscopy or other procedures to ensure safe removal. I understand that as part of the dental treatment, including preventive procedures such as cleaning and preventative dentistry, including fillings of all types, teeth may remain sensitive after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek, or other oral tissues to be inadvertently abraded or lacerated during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, or Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all risks, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results for my benefit or the benefit of my minor child. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature:_____ Date:_____

Acknowledgement of receipt of notice of privacy practices

*** you may refuse to sign this acknowledgement***

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

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):_____

ELEVATED FAMILY DENTISTRY

PATIENT NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996-(HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH Act), and associated regulations and amendments

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice or if you need more information, please contact:

Elevated Family Dentistry
Attn: Stephanie Elkins, Privacy Officer
801-756-4440
Or email at scheduling@elevatedfamilydentistry.com
70 W. Canyon Crest Road, Alpine, UT 84004

ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at Elevated Family Dentistry. We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

WHAT IS PROTECTED HEALTH INFORMATION ("PHI") PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:

• Your past, present, or future physical or mental health or conditions,
• The provision of health care to you, or
• The past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

• Treatment. We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

• Payment. We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

• Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

• Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

• Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
• Research. We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may disclose PHI to be used in collaborative research initiatives amongst Elevated Family Dentistry providers. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.
• As Required by Law. We will disclose PHI about you when required to do so by international, federal, state, or local law.
• To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
• Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.
• Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.
• Military and Veterans. If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.
• Workers' Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
• Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
• Abuse, Neglect, or Domestic Violence. We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
• Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
• Data Breach Notification Purposes. We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.
• Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process

from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.

• Law Enforcement. We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.

• Military Activity and National Security. If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law.

• Coroners, Medical Examiners, and Funeral Directors. We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

• Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

• Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

• Individuals Involved in Your Care. Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

• Payment for Your Care. Unless you object in writing, you can exercise your rights under HIPAA that your healthcare providers not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.

• Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

• Fundraising Activities. We may use or disclose your PHI, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. Your Written Authorization if Required for Other Uses and Disclosures The following uses and disclosures of your PHI will be made only with your written authorization:

• Most uses and disclosures of psychotherapy notes;

• Uses and disclosures of PHI for marketing purposes; and

• Disclosures that constitute a sale of your PHI. Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation. Your Rights Regarding Your PHI You have the following rights, subject to certain limitations, regarding your PHI:

• Inspect and Copy. You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

• Summary or Explanation. We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
• Electronic Copy of Electronic Medical Records. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.
• Receive Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured PHI.
• Request Amendments. If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
• Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12- month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
• Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.
• Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.
• Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by visiting our website: www.doctorbewell.com or contact the Elevated Family Dentistry office you are receiving services from.
• Changes to This Notice We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.
• Complaints: If you believe your privacy rights have been violated, you may file a complaint with Elevated Family Dentistry at the address listed at the beginning of this Notice or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Humans Services, 200 Independence Ave., S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775 or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. You will not be penalized for filing a complaint.