Welcome to our office! We appreciate you taking the time to complete the following forms.
Please complete every line item. Thank you!

PERSONAL INFORMATION

□ Dr. □ Mr. □Mrs. □Ms. **□Male □ Female** **Nickname:**_____

Patient Name: _____ **DOB:**_____/_____/_____

Patient Social Security #:_____ **Patient's Employer:**_____

Mailing Address:_____
Street **City** **State** **Zip Code**

Person Responsible for Account: _____ □ Self □ Spouse □Parent □Guardian □Other

Billing Address:_____
Street **City** **State** **Zip Code**

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

Email:_____ **Student?** □Yes □ No **School name & location:**_____

Emergency Contact Information: Name: _____ **Phone #:**_____

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

Has Dr. Vetter ever treated a family member or friend: Y N Name:_____

Dentist:_____ **Orthodontist:** _____

INSURANCE INFORMATION

DENTAL Insurance

Insurance Co. Name:_____
Insurance Address:_____
_____
Group #:_____ **Subscriber ID #**:_____
Insurance Policy Holder:_____
Employer (for group plans):_____
DOB:_____/_____/_____ SSN:_____-_____-_____

MEDICAL Insurance

Insurance Co. Name:_____
Insurance Address:_____
_____
Group #:_____ **Subscriber ID #**:_____
Insurance Policy Holder:_____
Employer(for group plans):_____
DOB:_____/_____/_____ SSN:_____-_____-_____

I hereby certify that the above information is true and correct to the best of my knowledge. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the provider named on the insurance benefits from unless otherwise stated payable to me.

Responsible Party Signature:_____ **Date:** _____/_____/_____

UPDATE: Initials:_____ Date: _____ Initials:_____ Date:_____ Initials:_____ Date:_____

Excellence in Oral & Maxillofacial Surgery, LLC

PATIENT HEALTH HISTORY

(Your responses are for our records only and will be strictly confidential)

Name:_____ Ht:_____ Wt:_____ Age:_____ DOB:_____/_____/_____

Are you currently under a physician's care? Y N If so, please explain:_____ Physician:_____

ALLERGIES:	Y	N		Y	N	
	__	__	Local Anesthetic	__	__	Penicillin's
	__	__	General Anesthetic	__	__	Sulfa Drugs
	__	__	Aspirin	__	__	Soy, Eggs, Milk, Peanuts
	__	__	Latex	__	__	Other: Please list_____
	__	__	Codeine/Narcotics	__	__	_____

MEDICATIONS: Please list all currently taking as well as past medications:_____

_____

PLEASE INDICATE YES OR NO FOR EACH OF THE FOLLOWING

Y	N		Y	N	
__	__	High Blood Pressure	__	__	Tumor or Growth
__	__	Chest Pain or Angina	__	__	Chemotherapy or Radiation
__	__	Heart Disease, Heart Attack	__	__	Seizures, Epilepsy
__	__	Heart Murmur, Mitral Valve Prolapse	__	__	Osteoporosis
__	__	Shortness of Breath	__	__	Bisphosphonate Medications
__	__	Stroke	__	__	Mental Health Problems
__	__	Cardiac Pace Maker and/or Defibrillator	__	__	Alcohol and/or Drug Abuse
__	__	Sinusitis, Seasonal Allergies	__	__	Arthritis
__	__	Asthma	__	__	Jaw Joint Problems
__	__	Emphysema	__	__	Diabetes
__	__	Tuberculosis	__	__	Thyroid Problems
__	__	Do You Smoke? # of packs per day_____	__	__	Anemia
__	__	Smokeless Tobacco? Years of Use_____	__	__	Sickle Cell Trait/Disease
__	__	Stomach Ulcers	__	__	Bruise Easily
__	__	Kidney Problems	__	__	Abnormal/Prolonged Bleeding (Disorder)
__	__	Joint Problems/Replacements	__	__	Liver Disease or Hepatitis
__	__	Do you have any problems chewing or eating?			
__	__	Do you have any breathing problems?			
__	__	Do you snore, or have you been told you do?			
__	__	Is there anything else we should know? Please explain.			
__	__	Would you like to discuss anything in private?			
		If yes, with:___Surgical Asst ___Doctor ___Practice Manager			

Female Patients

Hormone Replacement Therapy Y___ N___
Birth Control Pill/Patch/Injection/Other Y___ N___
Pregnant? Y___ N___ Nursing? Y___ N___

I hereby certify that the above information regarding the medical history of _____ is complete, true, and correct and may be relied upon for all purposes by ***Excellence in Oral and Maxillofacial Surgery, LLC,*** *their assistants, associates, and any other persons treating or assisting in the treatment of the patient.*

Signature:_____ Date:_____/_____/_____

Provider/Witness:_____ Date:_____/_____/_____

UPDATE: Initials:_____ Date: _____ Initials:_____ Date:_____ Initials:_____ Date:_____

Excellence in Oral and Maxillofacial Surgery, LLC

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnosis, treatment and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such a specialist and obtain input.

Example of use of your health information for payment purposes:

We submit a request for payment to your health insurance company. The Health Insurance Company requests information from us regarding medical care given. We will provide information to them about you and the health care given.

Example of use of your information for health care operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted.
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise that right by delivering the request in writing to our office.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office.
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to your office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office.
- Revoke authorizations that you made previously to use or disclose information except to the extent of information or action that has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Dr. Vetter at 719-592-9222, in person, or in writing during normal business hours. He will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we cannot accommodate a requested restriction or request
- Accommodate your reasonable requests regarding methods to communicate health information with you

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our notice. You are entitled to receive a revised copy of the notice by calling and requesting a copy of our "notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Dr. Vetter at 719-592-9222.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint in person to our office. You may also file a complaint by mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services as a condition of receiving treatment from the practice.
- We cannot, and will not retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member, personal representative, or other person responsible for your care, about your location and about your general condition.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object, or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse and Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in the Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Excellence in Oral & Maxillofacial Surgery, LLC

_____/_____/_____
Today's Date (Effective Date)

I, _____, hereby acknowledge that I have read this practice's ***Notice of Privacy Practices*.** I have been given the opportunity to ask any questions I may have regarding this notice.

(Print Patient's Name)

Signature of Patient or Guardian **Print Name** **Today's Date**

WITH WHOM MAY WE SHARE YOUR PERSONAL OR FINANCIAL INFORMATION?

NAME	**RELATIONSHIP**
1) _____	_____
2) _____	_____
3) _____	_____

UPDATE: Initials:_____ Date: _____ Initials:_____ Date:_____ Initials:_____ Date:_____

Excellence in Oral & Maxillofacial Surgery, LLC

Thank you for selecting our practice for your healthcare services. We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can sometimes be. To begin, we would like to highlight a misconception. Dental insurance was not designed to pay off ***all*** dental care costs. Most contracts have limits and/or various degrees of co-payments.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality surgical care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood that the dental insurance contract is between the insurance company and the policy holder (patient), and the patient/guarantor bears the ultimate financial responsibility.

As a courtesy to you, we will bill your insurance company for all services rendered, however, please be aware that the patient/guarantor is responsible for any deductible and/or coinsurance (%) on the day that services are rendered. Once insurance has made any payment, you will receive a patient statement for the balance due or a refund if one is owed. It is expected that this payment will be made within thirty (30) days. If payment is not received, it will be considered **past due** and may be sent to collections.

If you do not have insurance or if you have an insurance policy that Dr. James Vetter is not contracted with, please be advised that it is our office policy to request payment in full at time of service. We will be happy to assist you by submitting all insurance paperwork on your behalf with payment reimbursement to you directly.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our team for clarification on services, billing, or insurance.

Please acknowledge your understanding of this notice and your willingness to comply with the above by signing below.

Patient/Responsible Party Signature Date

Authorized Signature for Office Date

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining if. Failure to obtain the referral and /or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one percent (1%) per month or an **ANNUAL PERCENTAGE RATE** of twelve percent (12%). The finance charge on your account is computed by applying the periodic rate of 1% to the overdue balance of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of your suit, you agree the venue shall be in El Paso County, Colorado.

Returned Checks: There is a fee (currently $25.00) for any checks returned by the bank.

Missed Appointment Fee: The second time a patient does not show up on time for and appointment, or cancels with less than 24 hours notice, a $20 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with three (3) missed appointments will be asked to transfer their records to another doctor.

Credit History: In the event we do not receive payment, you give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Transfer of Records: You will need to request in writing and pay a reasonable copying fee if you would like to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Workers Compensation: We require written approval/authorization by your employer and/or Workers Compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for your payment in full.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

INITIAL_____DATE_____