Welcome to Our Practice

We would like to thank you for taking the time to contact our dental office. We know you have a choice when selecting a dental team to care for your health and we value the trust you have placed in us. We have prepared this informative packet so you may better understand our approach to helping you reach the best level of oral health possible. Many of the most common questions you might have will be answered in this packet, but if they are not, please do not hesitate to contact our office.

So that we can better serve you, please completely and accurately fill out the "Patient Registration, Medical History, Patient Questionnaire and Health Centered Dentistry" forms included in this packet. Bring them with you to your first appointment. If it is more convenient for you, you may fill out and submit the Patient Registration and Medical History Forms on our website at *www.bitterrootdental.com*. We encourage you to browse our website or our Bitterroot Dental Facebook page to learn more about us.

What We Do

Each person is unique, and so is their mouth. We may have the same number of teeth, but we may have different desires and expectations for those teeth. Our practice prides itself on delivering an excellent dental experience to each and every patient, every time. Our focus is to return mouths to optimal health and prevent further concerns over the patient's lifetime. When patients choose preventative measures, we are able to remain very conservative in our recommendations, thus saving you time and money in our office. We want to help you choose to have the least amount of dentistry possible in your lifetime. Our hygienist is incredibly successful in maintaining good oral health in patients who regularly visit her.

While prevention is our primary goal, we recognize we may have some work to do restoring good oral health. This is where Dr. Duke and his assistants excel. They can help you choose the options that are best for you to match your goals for the level of health you want.

Regardless how simple or complex your dental needs are, our team can help you reach your goals. Whether it's your six month checkup and cleaning, eliminating pain or broken teeth or replacing missing teeth you are in the right place! Check out our mission statement below.

Mission Statement

Our practice strives to provide each patient with the opportunity to choose excellent oral health. It is our responsibility to educate each patient of their current level of oral health and empower them to choose how they would like to improve that level of health. We believe the patient should choose for themselves what treatment they will receive. Our goal is to restore each patient's oral health to a level where conservative, regular maintenance care will prevent most serious oral conditions and the patient will receive maximal longevity from any work performed. We are dedicated to providing excellence in the quality of services we provide while creating an environment that will leave you with an amazing dental experience, every time.

Who is Dr. Duke?

Our dentist, David B. Duke, DMD, FICOI, graduated from the prestigious Case School of Dental Medicine in Cleveland, Ohio in 2008. While in dental school Dr. Duke spent countless hours volunteering in the free dental clinic nearby. Here he gained valuable experience and guidance from some of the best dentists in northeast Ohio. Dr. Duke also received training on placing and restoring implants as well as advanced bone grafting techniques during a nine month course in Chicago, IL and a hands-on surgical course in Orlando, FL through Implant Seminars. In December of 2009, Dr. Duke was awarded the advanced degree of Fellow in implants and bone grafting by the International Congress of Oral Implantology, the largest organization devoted to implants in the world. In March of 2014 he received an Associate Fellow award from the World Clinical Laser & Imaging Institute, the world's largest group of laser dentists. He is committed to providing excellence in all phases of dentistry and has earned more than 550 hours of continuing education classes in the past 6 years (far more than the 60 hours required every three years by the State of Montana). In addition to his distinguished membership as a Fellow in the International Congress of Oral Implantology and an Associate Fellow in the World Clinical Laser & Imaging Institute, Dr. Duke belongs to the American Dental Association, the Montana Dental Association, the Academy of General Dentists, the American Academy of Cosmetic Dentistry, the Three Rivers Study Club and the renowned Seattle Study Club. Prior to dental school Dr. Duke earned degrees in Cellular and Molecular Biology and Chemistry and Biochemistry at Utah State University and attended graduate school at Case Western Reserve University where he studied Applied Anatomy. He then taught at Walla Walla Community College.

Dr. Duke and his wife Annika love raising their three kids in Missoula. His interests include traveling, photography, whitewater kayaking, mountain biking, rock climbing, skiing, snowboarding, snowshoeing, backpacking and soccer.

Financing

Our office does require payment on the day of service. We will happily assist you in obtaining the maximum benefit allowed by your insurance. We also have flexible financial options that will allow you to fit your dental needs into your budget.

Unique to our office, we offer Illumisure for patients who do not have insurance. Illumisure is a dental discount plan for our office only. Illumisure helps everyone save money while getting the work they need, when they need it without worrying about denials or maximum benefits. Everything is covered at a discount. For more information, contact our office or follow the Illumisure link on our website.

What to Expect on Your Initial Visit

In order to provide you with individualized care most appropriate for you we feel it is important to spend time getting to know you and what it is you want for your dental health. During your initial visit there will be plenty of time for you to ask questions or discuss anything you feel would help us better help you with your dental health.

We will familiarize ourselves with your medical history and perform a comprehensive evaluation of your teeth and current dentistry, your gums and the bone that holds your teeth, the muscles that move your jaw joints, the jaw joints, your bite, your smile, how everything fits together and an oral cancer screening. We may ask permission to take various digital photographs of you and your teeth. We may ask permission to take various types of x-rays so we have the most current information to use to make the most accurate diagnosis. We may ask permission to take study models of your teeth and record how they fit together. We may also ask permission to contact your previous dentist(s) and your physician to ask them for x-rays and other relevant records. In some cases, the hygienist may perform the necessary treatment.

In situations where complex or extensive treatment is required, we may ask you to return to gather more information or to allow you ample time to review your options and ask questions. We strongly believe one type of treatment is not best for everyone so to best deliver ideal *individualized* care we take our time developing a plan and avoid rushing you into uncertain treatment. You will always be given more than one treatment option in our office. *This is only possible because we are not contracted with any insurance company. We work for you, not your insurance company!!*

For your initial comprehensive evaluation visit you can expect to be in our office for anywhere from 1 ½ to 2 hours so please make sure you allow at least that much time in your schedule.

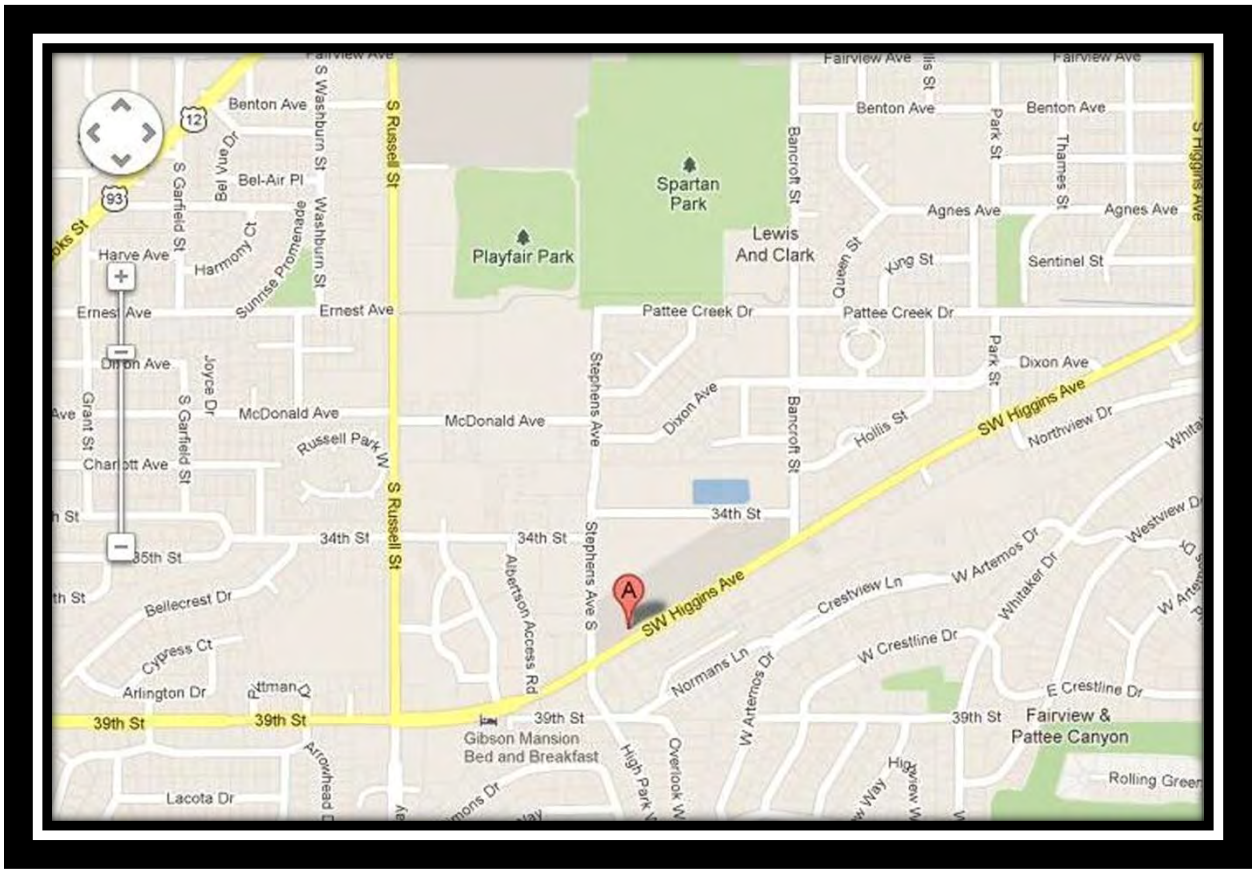
Changing Appointments

We see patients by appointment only. We expect that when you ask us to reserve an appointment for you in our schedule that you will find a time that has zero chance of having to be changed. We are only able to run the type of patient-focused practice we have by keeping appointment changes to an absolute minimum. Changing appointments at the last minute or missing appointments without letting us know is unacceptable. It prevents us from providing you or other patients with the healthcare they need in a timely manner. Often, patients in need of urgent care are made to wait so we can honor your scheduled time as first priority. When you cancel without notice, these patients wait unnecessarily for dental care, often in pain.

If a change is unavoidable, you must give us 48 business hours notice. Cancellation messages cannot be left on our answering machine. If your appointment is on Monday, you must let us know the previous Thursday if a change will be necessary. Failure to do so will result in a Late Notice or Cancellation Fee of $25 per half hour scheduled. If your schedule is unpredictable or changes without much notice, you may choose to call us on a day you are available and we will attempt to work you in.

Where Are We?

We are located above Palmer Drug at 918 SW Higgins. The entrance is on the side of the building facing the street. Parking is available next to our entrance near the billboard sign.



Office Hours

Our normal office hours are Monday, Tuesday, Wednesday and Thursday from 8am to 5pm with a lunch break between 1pm and 2pm. This schedule may change when Dr. Duke is attending continuing education courses, holidays, vacations or staff training. In case of an emergency, Dr. Duke's cell phone number is available at the end of the recording on the office phone number (721-3679).

MEDICAL HISTORY

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

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

Comments: _____

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 _____

Patient Registration Form

Patient name_____ **Birthdate** _____

Male_____ **Female**_____

Name of responsible party _____**Birthdate** _____

Home Phone _____**Cell Phone**_____ **Work Phone**_____

Social Security Number_____

Address _____**P.O. Box**_____

City _____ **State**_____ **Zip** _____

Email address_____

Employer_____ **Employer Phone**_____

Employer Address _____**State** _____**Zip**_____

Spouses Name_____ **Birthdate** _____

Social Security Number_____

Employer_____ **Employer Phone**_____

Employer Address_____**State**_____**Zip**_____

Insurance information

Name_____ **ID number** _____

Group number_____

Address_____

City_____ **State**_____ **Zip**_____

Relationship to Patient Self_____ **Spouse**_____ **Child**_____ **other**_____

Name and phone number of relative or friend not at your residence (emergency contact)

_____

New Patient Questionnaire

1. What is your primary reason or concern for your visit? _____

   _____

2. Are you currently experiencing dental pain? YES / NO

   If yes, please explain where and to what extent. _____

3. When was your last dental visit? _____

4. When were your last dental X-Rays? _____

5. When was your last cleaning? _____

6. How often do you brush? _____

7. How often do you floss? _____

8. Does dental care make you anxious or nervous? YES / NO

9. Do you feel you have active decay? YES / NO

10. Do you experience frequent bad breadth? YES / NO

11. Do you feel you have gum disease? YES / NO

12. Have you ever had gum treatments? YES / NO

13. Does food get caught between your teeth? YES / NO

14. Are you happy with your smile? YES / NO

    If no, please explain. _____

15. Would you like your teeth to be whiter? YES / NO

16. What are your dental expectations? _____

    _____

17. Are you currently experiencing dental pain? YES / NO

18. Is there anything you would like to change about the appearance of your teeth? YES / NO

    If yes, please explain. _____

    _____

Health Centered Dentistry

Four Levels of Dental Care

It is our desire to provide you with the highest quality dental care. Our goal is to help you become as healthy as you choose to be. In order to achieve this, we need to understand what your individual dental goals are. Please review the levels of dental care below and choose the one that most clearly describes the type of dental care that best suits your needs.

☐ Level 1 – Urgent Care

- People in crisis or with an emergency or accident need immediate help. We see emergencies immediately, whenever possible. This is not the primary focus of our practice.

☐ Level 2 – Corrective Care

- Patients who choose this level of care desire treatment only when something breaks or becomes uncomfortable. Generally, patients at this level prefer short-term cursory-type examinations, screening for more obvious advanced problems. They usually want to correct immediate problems with as little effort as possible. People at this level are not yet ready for either thorough or preventative treatment.

☐ Level 3 – Maintenance Care

- The people who chose this level of care want to take an active part in the prevention of present and future disease problems, but choose repair solutions that are more short range in duration. Usually they choose 2-5 year reparative or corrective treatment, knowing full well that the dental treatment performed today will be repeated again in the future.

☐ Level 4 – Optimum Care

- Patients at this level are similar to the people described in Level 3. They choose to have comprehensive examination and master planning and formulate a long-term treatment plan for health and repair to achieve a future based on choice, not chance. Unlike the maintenance care patient, these patients want all treatment to be completed in the most lasting fashion possible. They are happy to take an active role in their achievement of optimal oral health.

“The Agreement”

If you would like us to help you with your dental health then we feel it’s important for us to agree on what you should be able to expect from us and on what we should be able to expect from you. We look at this as a sort of “agreement” between us.

Here is what you can expect from us

1. You can expect us to take the time to get to know your individual needs and wants and not treat you as just another warm body with teeth to fix. You can expect us to develop a Master Plan for your health that is appropriate for you.
2. You can expect us to be respectful of your time and schedule by being as on time as humanly possible. Nobody likes to be kept waiting. If we have to change your appointment you can generally expect us to give you at least a week’s notice.
3. You can expect us to discuss financial issues with you before we perform substantial amounts of dentistry. You can expect us not to spend your money without your consent.

Here is what we expect from you

1. We expect that if you and we agree on a Master Plan to help you with your dental health that you will commit to moving through that plan at whatever pace is appropriate for you.
2. We see patients by appointment only. We expect that when you ask us to reserve an appointment for you in our schedule that you will find a time that has zero chance of having to be changed. We are only able to run the type of patient-focused practice we have by keeping appointment changes to an absolute minimum. Changing appointments at the last minute or missing appointments without letting us know is unacceptable. It prevents us from providing you or other patients with the healthcare they need in a timely manner.
3. We expect that you will honor the financial arrangements you make with our practice.

NOTICE OF PRIVACY PRACTICES

Bitterroot Dental, P.C. David B. Duke, D.M.D., FICOI
918 SW Higgins Ave. Missoula, MT 59803
406-721-3679 (Phone) 406-728-9056 (Fax)

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.

We respect our legal obligation to keep health information that identifies your private information. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us; communication for services by a laboratory. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; dental software updates and technical support; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for any reason, for a referral or medical consult, for example, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;

- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; more military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- Any other reason, as applicable or required by Montana State or Federal Laws.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call, text, email or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call, text, email or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have on 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax of E mail shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know received the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax of E mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Bitterroot Dental, P.C. Notice of Privacy Practices.

Patient name_____

Signature_____**Date**_____

Payment Policy

Bitterroot Dental
David B. Duke, DMD, FICOI
918 SW Higgins, Missoula, MT 59803
(406) 721-3679 phone (406) 728 9056 fax

Our office is a Fee-For-Service practice. Fee-For-Service means payment in full is due at the time service is rendered.

For patients without insurance, we accept cash, check, Master card, or VISA as forms of payment. We are also proud to offer Care Credit payment plans. **Care Credit payment plans allow affordable monthly payments for up to one year, interest free with no fees or finance charge.** Ask the front desk for more information on Care Credit.

Our office is proud to offer Illumisure dental discount plans for patients without insurance. Ask our staff about Illumisure and how you can save money if you do not have insurance.

For patients with insurance we will call your insurance company to obtain an **estimate** of what benefits they **may** pay. The actual portion you are responsible for may be higher or lower than this estimate based on the actual amount the insurance company pays. You are responsible for knowing the benefits of your insurance plan. You are responsible for paying the difference between the estimation (EOB) and the total cost of service at the time of service. For example, if the estimated insurance benefit is 70% the cost of treatment, you will be responsible for paying the remaining 30% the day of service. Care Credit payment plans are available to assist you with your portion of the payment. **Care Credit payment plans allow affordable monthly payments for up to one year, interest free with no fees or finance charge.** Ask the front desk for more information on Care Credit.

After the insurance has paid the claim, if there is a credit due to you, a check will be issued to you at the address we have on file. If there is any remaining balance on the account, that amount is due in full the following billing period. **Partial payments are not permitted without prior agreement by this office.** If the insurance company sends you the check, you are responsible for remitting that check to us, along with any remaining balance. Failure to remit the insurance check to us in full within ten business days of receipt will possibly result in substantial late fees, interest penalties, collections and contacting of your insurance company and the IRS for unreported income. As a courtesy, we do not charge you up front for your insurance company's portion. When you keep the check, you are essentially paying yourself for our hard work. We are polite and wait to get paid, so please don't abuse this generosity.

If your insurance company denies a claim, you are responsible for remittance of the balance in full. To assist in this unfortunate situation, we encourage you to utilize Care Credit payment plans if you are unable to pay the full balance.

I understand monthly statements will be mailed to me once the insurance company has paid or denied the claim. I understand the remaining balance is due in full at that time and partial payments are not permitted. I acknowledge a 2.0% per month interest finance charge will be assessed to unpaid balances. Late payments on contracted balances are subject to a late fee. I am solely responsible for ensuring the address and phone number on file at Bitterroot Dental, PC is accurate and up-to-date.

Should I fail to pay my balance as agreed upon in the above terms, I understand Bitterroot Dental, PC may choose to employ an independent agency or other legal avenue to collect the balance due. I understand that I will be responsible for paying any costs, fees, interest and legal or court costs incurred by Bitterroot Dental, PC in attempting to collect this money.

I acknowledge I have read and understand, or have had the payment policy read to me and explained to me. I agree I am responsible for payment of dental services provided to me by Dr. David B. Duke according to the above payment terms.

Signature_____ Date_____

Witness_____

RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: ___/___/____

A copy of the office HIPAA Privacy Policy is available at the front desk for your convenience. I authorize the release of any medical information necessary to process the claim to my insurance company or to any medical facility necessary to complete my treatment.

Please check one of the following:

In addition, I authorize the release of information including the diagnosis, records, examination rendered to me and all billing and claims information to the following people: **(please list by name)**

( ) Spouse: _____

( ) Children: _____

( ) Parents: _____

( ) Other: _____

( ) Information is not to be released to anyone other than my insurance company or a medical facility.

This Release of Information will remain in effect until terminated by me in writing.

Patient Signature: (parent if minor) _____
Relationship to patient: _____ Date: _____

Attendance "Agreement"

Whenever a patient schedules an appointment with us we reserve the time specifically for that patient. Two concerns arise when a patient does not keep the appointment, shows up late or cancels less than 48 hours before their appointment:

- Frequent cancellations and missed appointments lead to more dental disease and poor oral health. More dental disease means greater costs for the patient.
- Other patients who requested that time were denied access and open time is lost time for us.

We consider a scheduled appointment a commitment by both you and by this office. Because we schedule only one patient at a time, we are instituting a No-Show/Late Cancellation Fee for all scheduled appointments.

All patients that schedule an appointment with us will be charged $25.00 per half –hour of scheduled appointment time if they fail to keep an appointment or if a cancellation is not received within 24 hours of the appointment.

If we need to cancel your appointment without giving you 48 hours notice, we will credit your account $25.00 for each half-hour of scheduled appointment.

Patients may choose to be placed on a waiting list instead of scheduling an appointment and not run the risk of acquiring a No-Show/Late Cancellation Fee.

Please indicate your preference:

For Scheduled appointment time, would you like a reminder?
_____Yes
_____No
Phone number: _____ Cell Phone (text) _____ E-mail: _____

May we contact you at work?
_____Yes Phone Number:_____

I have read the above and understand this policy.

Signature: _____Date:_____