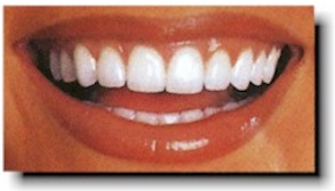
Intermountain Smiles



Benjamin Young, DDS

10011 S. Centennial Parkway Suite 525 Sandy, UT 84070
801-352-8288
www.IntermountainSmiles.com

General, Cosmetic and Implant Dentistry

Please fill out these forms as completely as possible. If you have any questions or need assistance please ask a staff member. We will be happy to help you.

Patient's name _____ Preferred Name_____

Date of birth _____/_____/_____ Marital Status _____

Social Security # _____

Home address _____ Zip code_____

Home phone _____ Cell phone _____

E-mail_____

☐ Check this box if you prefer ***not*** to receive appointment reminders by email or text.

How did you hear about our office?_____

Occupation _____ Work Phone _____

Employer _____

Emergency Contact _____ Phone _____

RESPONSIBLE PARTY/INSURANCE INFORMATION

Name of Account Holder _____ SSN or ID#_____

Date of birth _____/_____/_____ Group or Policy #_____

Insurance Carrier _____

Employer _____

Intermountain Smiles

Benjamin Young, DDS

Please be advised of the following financial, insurance, and privacy policies:

- ***If you have dental insurance:*** The responsible party is accountable for all dental bills in our office. Our staff will help with completion and submission of primary insurance forms as an accommodation and convenience to you. It is the patient's responsibility to know their insurance benefits, assure collection of insurance payments, and to negotiate with the insurance company over any disputed claims. Some insurance policies may allow, but do not cover certain procedures such as lab fees and/or diagnostic tests. Any co-payments are due at the time of the appointment unless other arrangements have been made. Some insurance policies allow for an alternate benefit on selected procedures. In the event of such, the patient is responsible for any difference in allowable co-pay. Many insurance carriers do not cover cosmetic procedures; if this is the case the patient is responsible for the full payment of these services. We may be able to assist you with any questions; please don't hesitate to ask. As a service to you, your insurance will be billed with your consent upon signing this form.

- ***Health Insurance Portability and Accountability Act of 1996:*** This office is in compliance with regards to the electronic submission of patient information to third party payers. All patient records are maintained on a secured database with access by employees of Intermountain Smiles only.

- ***If you do not have insurance:*** Payment in full is expected at time of service or advance financial arrangements must be arranged.

- ***Forms of payment:*** We accept payments in cash, check, money order, or most major credit cards. We can also assist you in applying for health care credit through a third party program.

- ***The responsible party agrees to:***
  1. Pay the doctor at the time service is rendered.
  2. Pay 2% per month (24% annually) on the unpaid balance with a minimum charge of $2.00 repeat billing fee per month on balances over 60 days.
  3. Cover the balance of this account within 60 days from the date of service in the event the insurance company does not pay the entire balance within that time.
  4. Returned check fee of $25.00, or the maximum allowable by law.
  5. Pay on past-due amounts, collection fees of up to 40% of the principal owing (U.C.A. sec. 12-1-11), court costs and attorney fees.
  6. Unpaid accounts may be subject to collection fees.
  7. Pay a fee for failing to keep a confirmed appointment or canceling with less than 24 hours notice.

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. In addition to receiving a written copy of this Notice, it may be viewed online at www.intermountainsmiles.com/privacy.htm

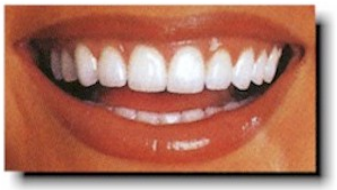
☐ **Check this box if you do not want us to discuss your treatment with *any* family members (Spouse, etc).**

I agree to the Financial Policy of this office and have read the privacy policy.

_____ _____

Signature *Date*

Intermountain Smiles



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PATIENT RIGHTS AND RESPONSIBILITIES INFORMATION SHEET

RIGHTS

1. The right to treatment with respect, consideration and dignity, provided in a safe environment, free from all forms of abuse or harassment. The patient may exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.
2. The right to privacy concerning your dental care.
3. The right to confidential treatment of all communications and records pertaining to your care and your visit(s). The patient also has the right to access information contained in your dental record within a reasonable time frame (24 hours of request, excluding weekends and holidays).
4. The right to be fully informed regarding one's oral health condition.
5. The right to participate in the development and implementation of your plan of care and actively participate in decisions regarding your dental care. To the extent permitted by law, this includes the right to request and/or refuse treatment. Information from Dr. Young about your dental health, your course of treatment, (including unanticipated outcomes), and prospects for recovery in terms you can understand.
6. The right to receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each.
7. The right to examine and receive the fees for service, the explanation of your bill and the payment policy regardless of source of payment. Upon request and prior to the initiation of care, receive an estimate of charges, potential insurance payments and an estimate of co-payment, deductible, or other charges not paid by insurance.
8. The right to understand and sign an Informed Consent form before receiving care.
9. The right to appropriate assessment and management of pain.

RESPONSIBILITIES

1. The patient has the responsibility to provide complete and accurate information to the best of your ability concerning your health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
2. The patient and family are responsible for asking questions when they do not understand, what a staff member has told them about the patient's care or expectations of what they are to do.
3. The patient is responsible for following the treatment plan prescribed by Dr. Young.
4. The patient/guardian is responsible for a nominal fee for failure to keep a confirmed appointment or cancel within 24 hours of the scheduled appointment
5. The patient is responsible for knowing and providing your healthcare insurance information, and accepting personal financial responsibility for any charges not covered by your insurance, assuring the financial obligations of your care are fulfilled as promptly as possible.
6. The patient is responsible for the consequences if he/she refuses treatment or fails to follow Dr. Young's instructions.
7. The patient is responsible for being respectful of all the health care professionals and staff as well as other patients.
8. The patient is responsible for following office policies and procedures.
9. The patient is responsible for being respectful of office property and that of other persons in the facility.

I have read and fully understand the information in this form.

_____ _____

Patient/Guardian signature Date

MEDICAL HISTORY

Patient's Name: _____ Date of Birth: _____

Primary Care Physician's Name: _____

Please answer the following questions as completely as possible (circle "YES" or "NO")

1. Are you now or have you been under a physician's care within the past year? . . . . . .YES NO
   If yes, specify condition being treated _____
2. Do you take any medications, including birth control pills or health supplements? . . . . . .YES NO
   Please specify name and purpose of medications: _____
   _____
   _____
3. Women: Are you pregnant? . . . . . .YES NO
4. Have you had a total joint replacement? . . . . . .YES NO
5. Do you have or have you ever had any heart or blood problems? . . . . . .YES NO
6. Do you have or have you ever had high blood pressure? . . . . . .YES NO
7. Do you require antibiotic pre-medication for a heart condition or artificial valve? . . . . . YES NO
8. Have you ever taken Fosamax, Boniva, or another drug for osteoporosis? . . . . . .YES NO
9. Have you ever had hepatitis or liver disease? . . . . . YES NO
10. Have you ever been diagnosed as being HIV positive or having AIDS? . . . . . YES NO
11. Have you ever had (check any that apply):
    asthma _____ any blood disorder _____ tuberculosis_____
    diabetes _____ arthritis _____ heart attack_____
    kidney disease_____ immune system disorders_____other disease _____

12. Have you ever had an unusual reaction to, or are you allergic to any of the following drugs:
    Penicillin _____ Aspirin _____ Acetaminophen _____Sulfa Drugs_____
    Ibuprofen _____ Codeine _____ Other_____
13. Are you subject to fainting? . . . . . YES NO
14. Are you allergic to any local anesthetic? . . . . . YES NO
15. Do you use tobacco (smoke/smokeless)? . . . . . YES NO
16. Do you have any other allergies? If yes, please describe: _____
17. Have you ever had a nervous breakdown or undergone psychiatric treatment?. . . . . YES NO
18. Have you ever received counseling for excessive use of alcohol and/or prescription drugs? . . . . . .YES NO
19. Do you have bleeding or sensitive gums? . . . . . YES NO
20. If you are now in any dental pain, please explain: _____
    _____
21. When was your last dental visit? _____
22. Who was your previous dentist? _____
23. Are you interested in whitening your teeth in the near future? . . . . . .YES NO
24. Do you have any questions or concerns you would like to speak to Dr. Young about (crooked or chipped teeth, smile design, bad breath, frequent cold sores, teeth grinding, gaps between teeth, etc)? _____
    _____

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY KNOWLEDGE. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical and dental status. I authorize Dr. Benjamin Young and/or assistants to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility. 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, muscle soreness, and temporary or rarely, permanent numbness. I do voluntarily assume any and all possible risks, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of any foregoing procedures will be explained to me if necessary and I will be given the opportunity to ask questions. I understand that any pictures/images taken may be used for educational and/or promotional use.

Signature _____ Date _____
(Patient, legal guardian or authorized agent of patent)

Intermountain Smiles

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 20, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your

health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $20.00, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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 complain to 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.

Contact Officer: Ben Young
Telephone: 801-352-8288
info@IntermountainSmiles.com
10011 S. Centennial Parkway Suite 525 Sandy, UT 84070