

# HIPPA Form



Redefining Care

Patient Label

\_\_\_\_\_ **HIPAA**  
Initials I acknowledge that I received Spectra Health’s Notice of Privacy Practices and the Patient Bill of Rights that is effective as of January 26, 2004. I understand that I may ask questions about the Notice of Privacy Practices and the Patient Bill of Rights at any time. Spectra Health participates in Blue Alliance through ND Blue Cross. I can ask questions about this at any time.

X \_\_\_\_\_  
Signature Date

\* HIPAA: Acronym that stands for the **Health Insurance Portability and Accountability Act of 1996**, a US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

Patient Label

\_\_\_\_\_ **FINANCIAL AGREEMENT**  
Initials I hereby give authorization for payment of insurance benefits to be made directly to Spectra Health for services rendered. I understand that I am financially responsible for all charges. I certify that the information I have reported with regard to my insurance coverage is correct. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits from my insurance carrier. I further agree that a photocopy of this agreement shall be as valid as the original.

\_\_\_\_\_ **INFORMED CONSENT AND AUTHORIZATION TO TREAT**  
Initials I understand I have the right to be told the reason for the treatment/procedure(s), the benefits or risks associated with it, and other treatment options. I also authorize Spectra Health to do exams, treatments, order diagnostic tests, and to provide medications that the provider thinks are necessary to stay healthy.

\_\_\_\_\_ **OUTSIDE LAB AND X-RAY PROCESSING**  
Initials Spectra Health partners with outside organizations, such as Altru, for processing certain labs and x-rays. When processing by an outside organization is required, I understand that I am subject to their Patient Financial Rights & Responsibilities and may receive applicable billing from these sources. If you are uninsured and on the SpectraPlan, we may be able to assist with the cost of specific labs/x-rays processed at Altru.

\_\_\_\_\_ **SPECTRA HEALTH NO-SHOW POLICY**  
Initials I understand that after TWO (2) broken appointments at the Dental Clinic I am ineligible for treatment for SIX (6) months. Failure to give a 24hr notice for cancellations results in a broken appointment. Arriving 10 minutes late to an appointment may also result in a broken appointment.

\_\_\_\_\_ **ELECTRONIC MEDICAL RECORDS AFFILIATION AGREEMENT**  
Initials Your health records with Spectra Health will be stored in the same Electronic Medical Record as Altru. While your information could be visible to certain healthcare providers at Altru, there is an expectation that providers only access charts of their patients for the purpose of provided care. Altru and Spectra Health have methods of monitoring for inappropriate access into patient charts, which could result in termination, civil and criminal consequences.

\_\_\_\_\_ **I AUTHORIZE MY SPECTRA HEALTH CARE TEAM TO SHARE RELEVANT INFORMATION REGARDING MY CARE.**  
Initials As an integrated care setting, Spectra Health providers work as a team. This may require sharing relevant information among your Spectra Health care team.

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



Please list any past/current treatment or surgeries not listed above: \_\_\_\_\_

Do you have any environmental, food, or medication allergies?  Yes  No

If Yes, please list and describe reaction: \_\_\_\_\_

**CURRENT MEDICATIONS**

Medication	Dosage and How Often	Reason for Medication

X \_\_\_\_\_  
Signature Date

Name of Child (if applicable): \_\_\_\_\_

# SpectraPlan Eligibility



Redefining Care

Date: \_\_\_\_\_

Patient Label
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Financially Responsible Party: \_\_\_\_\_  
Last Name First Name M.I.

Billing Address: \_\_\_\_\_  
City State Zip Code

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email Address: \_\_\_\_\_

Please **circle** both your family size and your gross annual income in the chart below:

	ELIGIBLE FOR SPECTRAPLAN DISCOUNT PROGRAM				NOT ELIGIBLE FOR DISCOUNT PROGRAM
	GREEN - 100%	BLUE - 75%	GRAY - 50%	WHITE - 25%	
FPL%	0% - 100%	>100% - 133%	>133% - 167%	>167% - 200%	> 200%
SIZE	INCOME	INCOME	INCOME	INCOME	INCOME
1	\$0 - \$12,880	\$12,881 - \$17,130	\$17,131 - \$21,510	\$21,511 - \$25,760	\$25,761 & Above
2	\$0 - \$17,420	\$17,421 - \$23,169	\$23,170 - \$29,091	\$29,092 - \$34,840	\$34,841 & Above
3	\$0 - \$21,960	\$21,961 - \$29,207	\$29,208 - \$36,673	\$36,674 - \$43,920	\$43,921 & Above
4	\$0 - \$26,500	\$26,501 - \$35,245	\$35,246 - \$44,255	\$44,256 - \$53,000	\$53,001 & Above
5	\$0 - \$31,040	\$31,041 - \$41,283	\$41,284 - \$51,837	\$51,838 - \$62,080	\$62,081 & Above
6	\$0 - \$35,580	\$35,581 - \$47,321	\$47,322 - \$59,419	\$59,420 - \$71,160	\$71,161 & Above
7	\$0 - \$40,120	\$40,121 - \$53,360	\$53,361 - \$67,000	\$67,001 - \$80,240	\$80,241 & Above
8	\$0 - \$44,660	\$44,661 - \$59,398	\$59,399 - \$74,582	\$74,583 - \$89,320	\$89,321 & Above
9	\$0 - \$49,200	\$49,201 - \$65,436	\$65,437 - \$82,164	\$82,165 - \$98,400	\$98,401 & Above
10	\$0 - \$53,740	\$53,741 - \$71,474	\$71,475 - \$89,746	\$89,747 - \$107,480	\$107,481 & Above

- I am not eligible for the discount program based on family size and gross annual income on the table above. I understand that I can reapply at any time, if needed.
- I do qualify, but I am refusing to participate in the discount program. I understand that I can reapply at any time, if needed.
- Financially Responsible Entity is an organization (CPS, Head Start, etc.) not eligible to participate in the SpectraPlan.

X \_\_\_\_\_  
Signature Date

*If eligibility is indicated above, please note a full application and income verification is required to determine approval. Spectra Health Social Service Department would be pleased to assist with the full SpectraPlan application process. Please schedule an appointment with registration or call 701-757-2100 for further assistance.*

**FIXED SPECTRAPLAN DISCOUNT DENTAL SERVICES**

Partial Maxillary Dentures.....	\$900
	\$450 due at scheduling; balance due at appointment
Partial Mandibular Dentures .....	\$900
	\$450 due at scheduling; balance due appointment
Interim PD (Flipper, 1-2 teeth) Partials.....	\$500
	\$250 due at scheduling; balance due at appointment
Any Crown.....	\$780
	\$390 due at scheduling; balance due appointment
Addition to Partial Denture (Per Tooth) (Max of 2) .....	\$200 due at scheduling
Permanent Stainless Steel Crown.....	\$250 due at scheduling
Pulpal Debridement .....	\$50 due at scheduling
Root Canal .....	\$50 due at scheduling
Night Guards .....	\$250 due at scheduling
Internal Bleaching .....	\$250 due at scheduling

**FIXED SPECTRAPLAN DISCOUNT MEDICAL SERVICES**

Sublocade (Per Dose) .....	\$1500 due at scheduling
Vivitrol (Per Dose) .....	\$1000 due at scheduling
Flu Vaccine & Administration.....	\$30 due at appointment
Shingrix Vaccine (Per Dose) (age 50 and older).....	\$150 due at appointment
Zoster Vaccine (Per Dose) (age 50 and older) .....	\$200 due at appointment
Varicella Vaccine (Per Dose) (age 19 and older) .....	\$95 due at appointment

**SERVICES NOT COVERED BY THE SPECTRAPLAN**

DOT Physical.....	\$110 due at appointment
Sports Physical.....	\$30 due at appointment
Camp Physical.....	\$30 due at appointment
Substance Use Assessment.....	\$145 due at appointment

**\* Pricing is specific to each device/procedure. Additional charges may be incurred during a visit based upon medical necessity.**