HIPPA Form

Spectra HEALTH | Redefining Care

Patient Label

_____
Initials

HIPAA

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.

Authorization Form

Spectra HEALTH | Redefining Care

Patient Label

_____
Initials

FINANCIAL AGREEMENT

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.

_____
Initials

INFORMED CONSENT AND AUTHORIZATION TO TREAT

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.

_____
Initials

OUTSIDE LAB AND X-RAY PROCESSING

Spectra Heath 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.

_____
Initials

SPECTRA HEALTH NO-SHOW POLICY

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.

_____
Initials

ELECTRONIC MEDICAL RECORDS AFFILIATION AGREEMENT

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.

_____
Initials

I AUTHORIZE MY SPECTRA HEALTH CARE TEAM TO SHARE RELEVANT INFORMATION REGARDING MY CARE.

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

Patient Health History Form

Spectra HEALTH | Redefining Care

Disclaimer: The information contained in this form is for the sole use of Spectra Health as is appropriate under the HIPAA Privacy Rule. These questions are asked in order to better serve you as a patient of Spectra Health.

Patient's Name:

_____

Last Name First Name Preferred Name Date of Birth

_____

Address City State Zip Code

Email Address: _____

Height: _____ Weight: _____ Insurance: _____

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Transgender Male (M to F)
☐ Transgender Female (F to M) ☐ Other ☐ Decline to Answer

Sexual Orientation: ☐ Lesbian or Gay ☐ Straight ☐ Bisexual ☐ Something Else
☐ Don't Know ☐ Decline to Answer

Preferred Pronoun: ☐ He/him/his ☐ She/her/hers ☐ They/them/theirs
☐ Ze/zim ☐ Patient's name ☐ Decline to Answer

PAST MEDICAL HISTORY

Have you ever been hospitalized? ☐ Yes ☐ No If Yes, what for? _____

Which of the following conditions are you currently being treated or have been treated for in the past? (Check all that apply.)

☐ ADHD
☐ Anemia
☐ Anticoagulant Therapy
☐ Anxiety
☐ Arthritis
☐ Arthritis, Rheumatoid
☐ Asthma
☐ Atrial Fibrillation
☐ Cancer – Type: _____
☐ Chronic Pain
☐ Congestive Heart Failure
☐ COPD
☐ Crohn's/Colitis
☐ Depression
☐ Diabetes
☐ Diverticular Disease
☐ Esophageal Reflux
☐ Fibromyalgia
☐ Gastric Ulcer
☐ Heart Disease
☐ Hearing Loss
☐ Hepatitis – Type: _____
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Irritable Bowel Syndrome
☐ Liver Disease
☐ Lung Disease
☐ Obesity
☐ Menopause
☐ Migraine Headaches
☐ Osteoporosis
☐ Peripheral Vascular Disease
☐ Pregnancy – Due Date: _____
☐ Renal Disease
☐ Seasonal Allergies
☐ Seizure Disorder
☐ Sensory Disorder – Explain: _____ _____
☐ Stroke Syndrome
☐ Traumatic Brain Injury
☐ Thyroid Disease
☐ Valvular Heart Disease

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

Spectra HEALTH | Redefining Care

Date: _____

Financially Responsible Party: _____
Last Name First Name M.I.

Billing Address:

_____
City State Zip Code

Phone: (_____) _____-_____ Social Security #: _____-_____-_____

Date of Birth: _____ Email Address: _____

Family Size: _____ (please write down the total number of people in your household)
Using your family size and gross annual income, please **circle** your income range in the table below:

	ELIGIBLE FOR SPECTRAPLAN DISCOUNT PROGRAM				NOT ELIGIBLE FOR DISCOUNT PROGRAM
	GREEN - 100% FPL% 0%-100%	BLUE - 75% FPL% >100%-133%	GRAY - 50% FPL% >133%-167%	WHITE - 25% FPL% >167%-200%	FPL% > 200%
FAMILY SIZE	INCOME	INCOME	INCOME	INCOME	INCOME
1	$0 - $14,580	$14,581 - $19,391	$19,392 - $24,349	$24,350 - $29,160	$29,161 & Above
2	$0 - $19,720	$19,721 - $26,228	$26,229 - $32,932	$32,933 - $39,440	$39,441 & Above
3	$0 -$24,860	$24,861 - $33,064	$33,065 - $41,516	$41,517 - $49,720	$49,721 & Above
4	$0 -$30,000	$30,001- $39,900	$39,901 - $50,100	$50,101 - $60,000	$60,001 & Above
5	$0 -$35,140	$35,141 - $46,736	$46,737 - $58,684	$58,685 - $70,280	$70,281 & Above
6	$0 -$40,280	$40,281 - $53,572	$53,573 - $67,268	$67,269 - $80,560	$80,561 & Above
7	$0 -$45,420	$45,421 - $60,409	$60,410 - $75,851	$75,852 - $90,840	$90,841 & Above
8	$0 -$50,560	$50,561 - $67,245	$67,246 - $84,435	$84,436 - $101,120	$101,121 & Above
9	$0 -$55,700	$55,701 - $74,081	$74,082 - $93,019	$93,020 - $111,400	$111,401 & Above
10	$0 -$60,840	$60,841 - $80,917	$80,918 -$101,603	$101,604 -$121,680	$121,681 & Above

Please check **only one** box below:

☐ I **WANT** to be contacted by Spectra Health to complete a full SpectraPlan application based on my eligibility information.

☐ I **DO NOT** want to be contacted by Spectra Health to complete a full SpectraPlan application. In understand I can reapply for the SpectraPlan at any time.
Common reasons for not participating in the SpectraPlan are:

- A third-party agency is responsible for patient payment.
- You are not eligible to participate due to income.
- You are not interested in participating but can reapply at **any** time.

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.

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SPECTRAPLAN FIXED DISCOUNT DENTAL SERVICES

		GREEN	BLUE	GRAY	WHITE
NOMINAL FEE	SERVICE	TOTAL COST	TOTAL COST	TOTAL COST	TOTAL COST
$900	▲ Partial Maxillary Dentures	$900	$930	$960	$990
$900	▲ Partial Mandibular Dentures	$900	$930	$960	$990
$200	● Repair/Addition to Denture (Per Tooth) (Max 2)	$200	$210	$220	$230
$500	▲ Interim PD(Flipper 1-2 Teeth) Partials	$500	$530	$560	$590
$780	▲ Any Crown	$780	$800	$820	$840
$250	● Permanent Stainless Steel Crown	$250	$260	$270	$280
$50	● Pulpal Debridement	$50	$60	$70	$80
$50	● Root Canal	$50	$60	$70	$80
$250	● Night Guards	$250	$260	$270	$280
$250	● Internal Bleaching	$250	$260	$270	$280

▲ **50% of Balance Due at Scheduling – 50% Due at Appointment**
● **100% of Balance Due at Scheduling**

Larimore Clinic
607 Towner Avenue
Larimore, ND 58251
701-343-6418

Grand Forks Clinic
212 South 4th Street, Suite 301
Grand Forks, ND 58201
701-757-2100

Grand Forks Dental Clinic
212 South 4th Street, Suite 101
Grand Forks, ND 58201
701-757-2100

Business Center
212 South 4th Street, Suite 200
Grand Forks, ND 58201
701-757-2800

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