

HIPAA Form



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 patient's medical records and other health information provided to health plans, doctors, hospitals and other health care providers.



Authorization Form

Patient Label

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 and accept responsibility for any fees for services not covered by my insurance or sliding fee scale assignment. I certify that the information I have reported regarding my insurance coverage is correct. I hereby authorize Spectra Health 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.

Outside Lab and X-Ray Processing

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 Spectra Plan, we may be able to assist with the cost of specific labs/x-rays processed at Altru.

Spectra Health No-Show Policy

I understand that after two broken appointments in a six-month period at the Dental Clinic, I am ineligible for treatment for six months. I understand that if I am late by 10 or more minutes to a medical appointment, I will be asked to reschedule my appointment. I understand that two consecutive broken specialty mental health appointments or chemical dependency evaluations will result in the cancellation of any outstanding appointments after the second missed appointment.

Electronic Medical Records Affiliation Agreement

Your Health records with Spectra Health will be stored in the same Electronic Medical Record as Altru Health Systems. While your information could be visible to certain health care providers at Altru, providers only access charts of their patients for provided care. Altru and Spectra Health have methods of monitoring for inappropriate employee access to patient charts and disciplinary policies related to inappropriate chart access.

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.

Substance Use Disorder and Mental Health Treatment

I understand that my substance use disorder and mental health treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written authorization unless otherwise provided for by the regulations.



Authorization Form

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Behavioral Health and Primary Care Telehealth Consent

I consent to receive primary care and behavioral health services through telehealth. I understand that the provider of my visit will be in an alternate approved location. A telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. Spectra Health telehealth service uses a secure web-based system for transmitting audio and video data. To ensure privacy, the data is encrypted at the highest level available for telehealth.

I understand that telehealth services are considered a proxy for direct face-to-face treatment, but certain risks exist. I understand that risks for using telehealth services can include, but are not limited to, technology interruptions, unauthorized information access, technology difficulties, or the need to have a visit performed in-person.

I understand that I can decline telehealth services at any time with no impact to future care, treatment, or program benefits. I understand that the same confidentiality laws and protections for face-to-face visits apply to telehealth visits including the expectation of privacy, confidentiality, and to be informed of all people who will be present during my visit. I understand that I can access information from a telehealth visit or request records from a telehealth visit by submitting a written request to Spectra Health. I acknowledge that information related to my telehealth visit will not be released without my written consent. I acknowledge that billing will occur from my practitioner and may include a facility fee from the site from which I am presented.

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 understand that services provided at Spectra Health are voluntary and, I can refuse service at any time. I also authorize Spectra Health to do exams (including ocular dilation), treatments, order diagnostic tests, and to provide medications that the provider thinks are necessary to stay healthy. If I choose to participate in telehealth services, I acknowledge that my provider will explain to me how the video conferencing technology will be used.

I request that Spectra Health provide me and/or my family with care.

Patient -or- legal guardian signature

Date

If signed by legal guardian, please print name

Relationship to patient



Financial Registration

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)

Annual Income: _____ (please write down the amount of money your household earns in a year)

OR indicate both your family size and gross annual income range by circling them in the table below:

FAMILY SIZE	ELIGIBLE FOR SPECTRAPLAN DISCOUNT PROGRAM				NOT ELIGIBLE FOR PRGM
	GREEN - 100% FPL% 0%-100%	BLUE - 75% FPL% >100%-133%	GRAY - 50% FPL% >133%-167%	WHITE - 25% FPL% >167%-200%	FPL% > 200%
	INCOME	INCOME	INCOME	INCOME	INCOME
1	\$0 - \$15,960	\$15,961 - \$21,227	\$21,228 - \$26,653	\$26,654 - \$31,920	\$31,921+
2	\$0 - \$21,640	\$21,641 - \$28,781	\$28,782 - \$36,139	\$36,140 - \$43,280	\$43,281+
3	\$0 - \$27,320	\$27,321 - \$36,336	\$36,337 - \$45,624	\$45,625 - \$54,640	\$54,641+
4	\$0 - \$33,000	\$33,001 - \$43,890	\$43,891 - \$55,110	\$55,111 - \$66,000	\$66,001+
5	\$0 - \$38,680	\$38,681 - \$51,444	\$51,445 - \$64,596	\$64,597 - \$77,360	\$77,361+
6	\$0 - \$44,360	\$44,361 - \$58,999	\$59,000 - \$74,081	\$74,082 - \$88,720	\$88,721+
7	\$0 - \$50,040	\$50,041 - \$66,553	\$66,554 - \$83,567	\$83,568 - \$100,080	\$100,081+
8	\$0 - \$55,720	\$55,721 - \$74,108	\$74,109 - \$93,052	\$93,053 - \$111,440	\$111,441+
9	\$0 - \$61,400	\$61,401 - \$81,662	\$81,663 - \$102,538	\$102,539 - \$122,800	\$122,801+
10	\$0 - \$67,080	\$67,081 - \$89,216	\$89,217 - \$112,024	\$112,025 - \$134,160	\$134,161+

Sliding Fee Discount Program Screener

Spectra Health offers a sliding fee discount program, known as the SpectraPlan. Please note, a separate application and income verification is required for discount program determination. The SpectraPlan can assist with the cost of care for services at Spectra Health.

The family size and income information collected above indicates whether your household may qualify for the discount program at Spectra Health. You can decline to participate in the discount program. Please note refusing is declining ANY possible discount on future services. All discounts are subject to a Nominal Fee.

Please check **only one** box below:

- I WANT to apply for the SpectraPlan. I WANT to be contacted by Spectra Health staff to discuss completing a full SpectraPlan application and providing income verification.
- I DO NOT want to apply for the SpectraPlan. I do not want/need any discount on future services I receive at Spectra Health. I understand I can apply for the SpectraPlan at any time in the future if needed.

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.

X _____
Signature

Date

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. Please note the SpectraPlan discount program can NOT be applied to reduce any monthly Medicaid recipient liability for those patients for whom this applies.

SPECTRAPLAN FIXED DISCOUNT DENTAL SERVICES

NOMINAL FEE	SERVICE	GREEN	BLUE	GRAY	WHITE
		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.**



Designation of Consent for Another to Authorize Treatment

This form must be completed by the minor's parent or legal guardian.

It is best practice to see minors with their parent or authorized guardian present. If you cannot be present at the appointment with your minor, we are legally obligated to have your written authorization before we treat your minor.

This form allows you to pre-designate adults that can accompany your minor at future visits and consent to treatment for your minor by exercising their own best judgement upon advice of Spectra Health licensed personnel.

Our clinic staff and providers reserve the right to postpone any non-urgent procedure if proper consent cannot be obtained before the time of an appointment.

Minor Patient's Information			
Minor's First Name:	MI	Minor's Last Name:	Minor's Date of Birth:

Parent / Legal Guardian Information			
Parent / Guardian First Name:	MI	Parent / Guardian Last Name:	Date of Birth:
Relationship to Minor Patient:	Parent / Guardian Phone Number:		Alternate Phone Number:
If Authorized Guardian is a representative of a government agency, please list agency name:		Government Agency Phone Number:	

Additional Parent / Legal Guardian Information			
Parent / Guardian First Name:	MI	Parent / Guardian Last Name:	Date of Birth:
Relationship to Minor Patient:	Parent / Guardian Phone Number:		Alternate Phone Number:



Minors under 14 years of age must be accompanied to appointments by a parent, authorized guardian, or designated adult.

To help us best care for your minor, please identify **any** other adult that can accompany your minor to appointments. **These individuals must be over the age of 18.**

Please complete the next section of this form to designate adults that can accompany your minor to appointments and authorize treatment on your behalf.

Other adults authorized to accompany your minor to appointments at Spectra Health			
First and Last Name	Relationship to minor	Can accompany minor to visit?	Phone
		[] yes [] no	
		[] yes [] no	
		[] yes [] no	
		[] yes [] no	

Minors over the age of 14:

If your minor is over the age of 14, can they attend appointments without you, or without an approved designated adult?

[] No [] Yes

Dental Clinic Use Only

Extraction Appointments:

Due to the irreversible nature of extractions, I understand that a parent or legal guardian must be present for all extraction appointments involving my minor child, and no other adult can be designated to authorize this treatment or attend these visits.

Minor patients between the ages of 14 and 18 **must** be accompanied at these visits.

Parent / Guardian Signature

Date

Treatment Plan Consent:

I understand that dental treatment will be completed as listed on the treatment plan, I have signed separately, and that a parent or legal guardian must separately authorize the dental treatment plan.



Limitations:

Are there any limitations you would like to place on the treatment that Spectra Health may provide to your minor if you are not present at an appointment?

No Yes

If yes, please describe:

Parent / Legal Guardian Consent:

In an emergency, we will provide treatment and contact you as soon as possible. Urgency will be determined by our licensed professionals. Be advised that your minor's protected health information may be shared with the person(s) you designate on this form to accompany your minor to appointments. If you do not want protected information shared with these individuals, please designate that in the limitations section above.

I have the legal right to pre-authorize Spectra Health to deliver health care to my minor, listed above. I request and authorize Spectra Health and its personnel to deliver health care to my minor, listed above. I understand that every effort will be made to obtain proper consent prior to each visit. I understand that in an emergency situation, treatment for my minor will be initiated immediately and Spectra Health personnel will contact me as soon as possible. I understand that I am providing authority to the designated adult(s) to consent to treat my minor and exercise his or her own best judgement upon the advice of licensed Spectra Health personnel. The information provided on this form is true, correct, and complete to the best of my ability.

Parent / Legal Guardian Signature

Date

Parent / Legal Guardian Printed Name