HIPAA 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 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 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 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

Patient Label

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 _____

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 to better serve you as a patient of Spectra Health.

Patient's Name: _____ **Preferred Name:** _____

Address: _____ **Phone Number:** _____

Date of Birth: _____ **Height & Weight:** _____ **Insurance:** _____

Email: _____

Gender:
☐Male ☐Female ☐Transgender Male (f to m)
☐Transgender Female (m to f) ☐Non-binary
☐Decline to Answer ☐Other _____

Preferred Pronoun:
☐he/him ☐she/her ☐they/them/theirs ☐ze/zim
☐preferred name ☐Decline to Answer
☐Other: _____

Sexual Orientation: ☐Lesbian or Gay ☐Straight ☐Bisexual ☐Something Else ☐Don't Know ☐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?
(Please check)

☐ ADHD
☐ Anemia
☐ Anticoagulant Therapy
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Autism
☐ Cancer Type_____
☐ Chronic Pain
☐ Congestive Heart Failure
☐ COPD
☐ Crohn's/Colitis
☐ Depression
☐ Diabetes Last A1C_____
☐ Diverticular Disease
☐ Esophageal Reflux
☐ Fibromyalgia
☐ Gastric Ulcer
☐ Heart Disease
☐ Hearing Loss
☐ Hepatitis
Type_____
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Joint Replacement
☐ Lung Disease
☐ Liver Disease
☐ Menopause
☐ Migraine Headaches
☐ Need for Premedication
☐ Osteoporosis
☐ Pacemaker
☐ Peripheral Vascular Disease
☐ Pregnancy
Due Date _____
☐ Radiation Treatment
☐ Renal Disease
☐ Seizure Disorder
☐ Sensory Disorder
Explain_____
Explain_____
☐ Stroke Syndrome
☐ Traumatic Brain Injury
☐ Thyroid Disease
☐ Valvular Heart Disease

Medical treatment, conditions, 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	Reason for Medication

Signed _____ Date _____

Financial Registration

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)

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:

	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%
FAMILY SIZE	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.

Spectra HEALTH | Redefining Care

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.**