Demographic Information

Patient Information:

Last Name ______________________(Legal) First Name________________ Middle____________

Preferred Name__________________AKA___________________Date of Birth________________
SSN:_____________________ Language____________________

Gender M / F Primary Language________________ Race_____________ Ethnicity- Declined Non-Hispanic Latino Hispanic or Latino

Home phone__________________________________ Cell phone___________________________

Email Address____

Preferred Communications: Mail_____ Home phone_____ Cell Phone____Email____

Address:____

City:___________________________State:______________________Zip_____________________

Height:_______________ Weight:_______________ Neck Size______________ BMI_____________

Primary Care Physician:_________________________ Phone Number:______________________

Emergency Contact:________________________Phone Number:______________________Relationship:___________

Primary Insurance Information:

Type of Medical Insurance: Medicare HMO PPO Tricare Other N/A

Name of Insurance:_________________________________ Member ID#____________________

Group # _____________________________________ Insurance Phone#______________________

Policy Holder's Name______________________________ Date of Birth______________________

Relationship to patient_______________________________

Employer___________________________________ Occupation____________________________

Secondary Insurance Information (if applicable):

Type of Medical Insurance: Medicare HMO PPO Tricare Other N/A

Name of Insurance:_________________________________ Member ID#____________________

Policy Holder's Name______________________________ Date of Birth______________________

Relationship to patient_______________________________

Employer___________________________________ Occupation____________________________

Preferred Pharmacy ____

Effective Date April 7, 2023

DISCLOSURE OF FEES AND POLICIES

I understand that I am responsible for payment in full at the time of service. I understand that the Initial Consultation is a free service. However, if I decided to proceed with same day treatment, the consultation appointment will end and the appointment will turn into a New Patient Office Visit.

RDSS provides Home Sleep Studies for **$200**, which will be due at the time of service. If I have insurance I may be reimbursed for this fee if my insurance pays for the sleep study. New Patient Office visits are **$200**. Thereafter, office visits will be charged based on the time spent with the doctor or assistant. The cost for these office visits are as follows: **$110 for up to 15 minutes, $140 for up to 25 minutes, and $170 for time above 25 minutes.**

I can receive a cash discount if I do not have insurance or if my insurance determines the Oral Appliance is a non-covered benefit. The cash price for the Oral Appliance, an oral exam and x-rays is **$1700-$2000 (Depending on the type of appliance).** I understand that I will be billed for office visits. This includes adjustment and repair appointments. The cash price for office visits is **$100**.

Dependent upon the recommendations of the doctor, other fees for services received apply. A complete list of services received are available to me upon request in the form of a super-bill. All fees are subject to change without written notice. I am aware that billing my insurance is a curtesy and anything that they do not pay I may be billed for.

I have read, understand, and agree to the terms above.

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Patients Printed Name

_____________________________________ ________________

Signature of Patient or Guardian Date

Rogue Dental Sleep Solutions

124 NE Evelyn Ave
Grants Pass, OR 97526
Phone: (541) 936-9456 Fax (458) 219-6189
Email: info@roguedentalsleepsolutions.com

Effective Date April 7, 2023

Assignment and Release

I, the undersigned, certify that I, or my dependent, have insurance coverage with the above insurance company, and assign directly to Rogue Dental Sleep Solutions all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Rogue Dental Sleep Solutions to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ____

You are responsible for all deductible, co-pays, non-covered services, co-insurance, and items considered “not medically necessary” by your insurance company. You will be required to pay all out of pocket costs before an oral appliance can be made unless you have made special arrangements.

Returned checks will be charged an additional $25.00 fee and must be taken care of within 30 days or will be subject to collections.

Insurance Billing

As a courtesy, we will bill your insurance for you. If the insurance company has not paid within 90 days, the bill will be your responsibility. It is your responsibility to contact your insurance company with any questions as we are not able to do this on your behalf.

Missed Appointment Policy
We have set-aside the time for your appointment. In Lieu of charging a fee for missed appointments, we reserve the right to dismiss any person who does not keep an appointment or cancel within 24 hours of your appointment time.
I acknowledge by signing that I understand and agree to the above. If you have any questions before signing, please ask for assistance.

Signature of Responsible Party _________________________________**Date**_______________

Notice of Privacy Practices: Acknowledgement of Receipt

Acknowledgement of Receipt, by signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Rogue Dental Sleep Solutions. Our *Notice of Privacy Practices* provides information about how we may use or disclose your protected health information. We encourage you to review it carefully. Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice at our office or by electronic means if requested.

I acknowledge receipt of the *Notice of Privacy Practices* of Rogue Dental Sleep Solutions.

Signature of Responsible Party ____________________________**Date** ____________________

For office use only: Inability to obtain acknowledgement and reason why not obtained._______

THIS PAGE MUST BE COMPLETED BEFORE PATIENT CAN BE SEEN.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize: ____
(Name and address of current health care provider)

I authorize: ____
(Name and address of current dental provider)

To provide and disclose a copy of **ALL MEDICAL RECORDS PERTAINING TO THE PATIENT LISTED BELOW**: including, but not limited to, Immunization Records, Chart Summaries, Diagnoses, Treatments, Labs, and X-Rays:

Regarding:____
(Patient Name) (Date of Birth)

To:

Rogue Dental Sleep Solutions
124 NE Evelyn Ave
Grants Pass, OR 97526
Phone (541) 936-9456 Fax (541) 479-1613

For the purpose of ____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____**HIV/AIDS Information**
_____**Mental Health Information**
_____**Genetic Testing Information**
_____**Drug/Alcohol diagnosis, treatment, or referral information**

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to our privacy officer. Unless revoked earlier or otherwise indicated, this Authorization shall remain in effect for the duration of the Trustor's trust.

SIGNATURE: I have read this authorization and I understand it.

By:____________________________________ Date: _________________________________
(Signature of Patient)

By:____________________________________ Date: _________________________________
(Print Name of Patient)

Effective Date April 7, 2023

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires individually identifiable health information used or disclosed by us, whether electronically, on paper, or orally, be kept properly confidential. HIPAA gives the patient significant new rights to understand and control how health information is used. It also provides penalties for covered entities that misuse personal health information. We may use and disclose your medical records only for the following purposes:

• Treatment - Providing, coordinating, or managing health care and related services by one or more health care providers.

• Payment- Obtaining reimbursement for services, confirming coverage, billing, and collection activities

• Health Care Operations - Conducting quality assessment and improvement activities, auditing, cost management analysis, and providing customer service.

We may also create and distribute de-identified health information by removing all individually identifiable Information.

We may contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits and services, which might be of interest to you.

Any other uses and disclosures may be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights, which you can exercise by presenting a written request to our office.

• To request restrictions on certain uses and disclosures of protected health information. This includes disclosures to family members, other relatives, and personal friends, or other persons identified by you. We are not required to agree to requested restrictions. However, if we do agree to a restriction, we are obligated to abide by it, unless you agree in writing to remove it.

• To a reasonable request to receive confidential communications from us by alternative means or at alternative locations.

• To inspect and copy your protected health information.

• To amend your protected health information.

• To receive an accounting of disclosures of protected health information.

• To obtain a paper copy of this notice upon request.

This notice is updated and effective March 18, 2022 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provision effective for all protected health information that we maintain.

Should you feel your privacy protections have been violated, you may file a written complaint about violations of the provision of the notice or of the policies and procedures of our office, with this office or the Department of Health and Human Services, Office of Civil Rights (address below). We will not retaliate against you for filing a complaint.

For more information about HIPAA contact: The US Department Of Health and Human Services, Office of Civil Rights,

200 Independence Ave. SW Washington DC 20201 Phone 202 619-0257 or toll free (877) 696-677

Notice of Patient Privacy Health Insurance Portability and Accountability Act

Rogue Dental Sleep Solutions takes our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible medical care. We are dedicated to defending your right to and keeping a confidential relationship with your provider. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others to your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide you, and the related administrative activities supporting your treatment. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization. You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The effective date at the bottom of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy. If you have any questions, concerns, or complaints about the NOTICE or your medical information, please contact Rogue Dental Sleep Solutions at (541)936.9456. You may also send a written complaint to the US Department of Health and Human Services.

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Printed Name

____________________________________ _______________

Signature of Patient or Guardian Date