8340 S. Sangre De Cristo Rd, Ste 104
Littleton, CO 80127
303-948-4884

Heath J Parry, DMD, MDS
Berit K Ek, DMD
Randolph A Degerness, DDS, MS

PATIENT INFORMATION

Name ____________________________Address ____

City ____________________________State ______________Zip __________ Date ____________

Phone (H) ______________ (W) ______________ (M) ______________Date of Birth __________

General Dentist ________________ Employer ______________________ SS# __________________

Whom may we thank for referring you? ______________ Patient Email_____________________________

DENTAL INSURANCE INFORMATION

Name of Insured ______________________ Insured's SS#/ID#________________Insured's Date of Birth______

Relationship to Patient __________Insured's Employer __________________ Insurance Company ____________

Group # ________ Local#/Military Rank _____Insurance Company Address and Phone # _______________________

MEDICAL HISTORY

Physician's Name ____________________ Address ___________________________ Phone # ____________

Are you allergic to, or have you had side effects from, any of the following?

Penicillin	Yes	No	Aspirin	Yes	No	Local Anesthesia	Yes	No	Latex Allergy	Yes	No
Other Antibiotics	Yes	No	Codeine	Yes	No	Other Medication	Yes	No			

If yes to other, please list ____

Other environmental allergies ____

Do you have, or have you had, any of the following?

Heart Problems	Yes	No	Sinusitis	Yes	No	Bleeding disorder	Yes	No
High blood pressure	Yes	No	Thyroid treatment	Yes	No	Immune disorders	Yes	No
Low blood pressure	Yes	No	Asthma	Yes	No	Anemia	Yes	No
Heart Murmur	Yes	No	Tuberculosis	Yes	No	Blood disease	Yes	No
Rheumatic fever	Yes	No	Diabetes	Yes	No	Blood transfusion	Yes	No
Mitral valve prolapse	Yes	No	Kidney disease	Yes	No	Hepatitis	Yes	No
Arrhythmia	Yes	No	Colitis	Yes	No	Chemotherapy	Yes	No
Stroke	Yes	No	Arthritis	Yes	No	Radiation therapy	Yes	No
Seizure	Yes	No	Joint replacement	Yes	No			

Current medications ____

Recent hospitalizations ____

Have you ever been told to take antibiotic premedication prior to dental appointments? Yes No Do you still take them? Yes No

Women: Are you pregnant? ____________________Nursing? ________Do you use birth control pills? __________

Emergency contact name ______________ Relationship to patient ____________________Phone __________

Pharmacy (Preferred)_ ____________________ Address_ ________________________Phone____________

Patient/ Guardian Signature ____ Date __________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by law to maintain the privacy of your health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11/1/2022, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and t make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose your protected health information (PHI) for different purposes, including treatment, payment and health care operations. For example:

Treatment: We may use or disclose your health information to a healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services and treatment you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental or medical insurance plan containing certain health information.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Persons Involved in Your Care or Payment for Your Care: We may disclose health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities: Some information, such as HIV-related information, alcohol and/or substance abuse records, and Prevent or control disease, injury or disability;

- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient.

Secretary of HHS & Worker's Compensation: We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA and to the extent authorized by and necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Health Oversight Activities: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure, government programs, and compliance with civil rights laws.

Other Uses and Disclosures of PHI: We will obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $5.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before November 1, 2015. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **You must make your request in writing.** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured PHI as required by law.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Heath Parry, DMD, MDS

Telephone: 303-948-4884

E-mail: endo@andanteendo.com

Address: 8340 S. Sangre De Cristo Rd, Suite 104, Littleton, CO 80127

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Unless we have your written permission to do so, we will not leave messages on any voicemail/answering machine or with anyone other than you or your legal guardian regarding your health information with the exception of reminding you of an appointment. Please read below and consider carefully whom you want to have access to your health information.

I, ______________________________ give Andante Endodontics my permission to discuss information or leave phone messages regarding my health care with the following people using the following contact information. I understand that my health information may include diagnosis, treatment, treatment recommendations and or financial information. I fully understand that this consent will remain valid until revoked in writing.

_______Myself at my home/voice mail or answering machine: # __________________________

_______Myself on my cell/voice mail: # __________________________

_______Myself at my work/ Work Voice Mail: # __________________________

_______Via E-mail E-Mail Address:____________________________________

I Prefer: ______________________________________

OTHER:

______ Name: __________________________ Relationship: ___________________ # ______________

______ Name: __________________________ Relationship: ___________________ # ______________

____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received and/or been given an opportunity to fully read a copy of this office's Notice of Privacy Practices.

Printed Name: ____

Signature: ____ Date: _________________

FOR OFFICE USE ONLY: Note regarding refusal to sign

____

Andante Endodontics

Heath Parry, DMD, MDS

Berit Ek, DDS

Dr. Randolph A. Degerness, DDS, MS

Financial Policy

Many of our patients are fortunate enough to have some coverage by dental insurance. We strive to help maximize your dental plan benefits and as a courtesy, will submit claims to your insurance company on your behalf. It is impossible to know exactly what each dental plan covers. We will collect as much information about your dental benefits as possible and determine an **estimated co-payment** to be paid on the day services are rendered. If your treatment is not covered in our office by your insurance, or you do not have insurance, we ask that payment for services be paid the day treatment is rendered

For your convenience we accept cash, checks, VISA, MasterCard, and Discover. If you would like to discuss financial arrangements, please speak with our front office team. We would be happy to set-up a financial arrangement with our office.

Please be advised returned checks will be subject to an additional charge of $50.00 added to your account with our office.

No-Shows and appointments cancelled without 48 hours advanced notice will be charged $100.00 per hour of your reserved appointment. Charges may also apply to requested medical reports and records.

Please understand that if, for whatever reason, your insurance company denies all, or a portion of your claim, you will be responsible for all charges associated with services rendered. Our staff is willing to make reasonable attempts to provide any and all additional information required by your insurance company. If a claim is denied for any reason, you will then receive a statement for any remaining balance.

If you have any questions regarding your account or your insurance, please contact our office at 303-948-4884 and we will be happy to assist you.

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

The information I have provided to Andante Endodontics is true to the best of my knowledge. I understand that I am ultimately responsible to pay for all services rendered as well as reasonable attorney and collection fees in the event of default. I also hereby authorize Lone Tree Endodontics to furnish or obtain any/all information to/from insurance carriers, referring dentists or physicians, other offices/agencies to whom we refer, or designated next of kin or caregiver concerning treatment. I authorize my insurance company to send payment directly to Andante Endodontics.

Signature ____ Date __________________________

Andante Endodontics
Consent for Endodontic Therapy

I understand root canal treatment is a procedure to retain a tooth, which may otherwise need extraction. Root canal therapy has a high degree of clinical success; however, it is still a biological procedure so there is no absolute guarantee. A patient may experience post-operative discomfort, infection, swelling, limited opening or other complications, which may require additional treatment.

I, the undersigned, have been informed that if I require an endodontic procedure (root canal treatment), I fully understand the following:

- **Failure to follow recommendations may result in: a. The loss of the tooth, further infection, pain or damage to the surrounding tissues b. Bone destruction or sinus infection due to an abscess c. Possible systemic (affecting the whole body) infection.**
- **Other treatment options include no treatment, waiting for more profound symptoms or extraction of the tooth. The doctor will discuss the pros and cons of treatment and options.**
- **A percentage (5-8%) of root canals may fail. This may require retreatment, endodontic surgery or even extraction.**
- **During instrumentation of the tooth, an instrument may separate and lodge permanently in the tooth or an instrument may perforate through the canal wall. Although this rarely occurs, these are recognized complications which may warrant additional treatment, failure of the endodontic therapy, or even loss of the tooth.**
- **When making an access (opening) through an existing crown or placing a rubber dam clamp, damage could occur and a new crown or filling would be necessary. This would be at your expense.**
- **I understand that only root canal treatment is performed in this specialty office. The permanent (outside) restoration (filling, crown, onlay, etc.,) will be done by your regular dentist. This is NOT covered in the root canal fee. Successful completion of the root canal procedure does not prevent decay or fracture. It will be important to see your dentist for follow up care.**
- **There will be multiple radiographs and possibly a CBCT (3D scan) taken for treatment.**

I understand there are risks involved in the administration of anesthetics, analgesia (pain medication) and antibiotics. Though rare, I am aware that administration of local anesthetics could lead to a paresthesia or long term numbness. I must give an accurate medical history and disclose all medications, both prescribed and over the counter, that I am taking. I understand that antibiotics may decrease the effectiveness of birth control pills.

By signing below, I acknowledge that I have read this consent form in its entirety and have been given the opportunity to ask questions. By my signature, I hereby authorize the doctors to take radiographs, perform examinations, diagnostic procedures and any indicated treatment.

____
Tooth/Teeth #(s)

________________________________ ________________________________ ______________
Patient Name **Patient/Guardian Signature** **Date**