NEW PATIENT AGREEMENT

Thank you for trusting our office with your dental care. In order to maintain the high rapport and cooperation between the doctor and the patient necessary for a mutually satisfactory completion of the patient's dental care, we ask that you agree to the following:

I acknowledge that my appointment time is reserved specifically for me. I agree that if I can't make an appointment. I will call My Cherry Creek Dentist with Dr. Lowery's office at least 24 hours in advance so they can fill that time with another patient. If I do not give the office 24 hours' notice, I agree to pay an $80 cancellation fee.

I understand that I am responsible for paying for services rendered, co-pays or non-covered benefits at the time of service. I understand that any outstanding balance due more than 30 days will incur finance charges of 1.39%. I am responsible for the attorney's fees and costs of collection efforts if I do not pay my obligations for service to Teresa M. Lowery, DDS PC. (Dr. Lowery and her staff agree to make every effort to verify insurance and benefits. We also guarantee that you will be presented with a treatment plan for you to agree to prior to doing any procedure other than routine.) All statement and account balances will be emailed unless requested in writing otherwise.

We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Please understand that we will provide an insurance "guesstimate" to you, however, it is not a guarantee that your insurance will pay exactly as "guesstimate". Your insurance company and your plan benefits will determine the amount paid. We will, of course, do our best to make sure your "guesstimate" is as close as possible. **If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.** If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment will be expected immediately. We ask that you sign this form and/or any other necessary documents that may be required by your insurance company.

Signature of patient: _____

Dr.Lowery's signature: _____

Date:

_____

PRESCRIPTION DRUG MONITORING NOTIFICATION

By signing this form, you confirm that you have been notified that if you receive a prescription for a controlled substance (narcotic drug) from our office and fill that prescription at a pharmacy in Colorado, certain identifying prescription information, including the name of the patient, will be entered into a secure database maintained by Colorado's prescription drug monitoring program. State law requires pharmacies to report information about controlled substance prescriptions filled to the prescription drug monitoring database.

This database is used to help prevent inappropriate uses of controlled substances - like fraud and diversion. The prescription drug monitoring program database contains only records related to controlled substances (narcotic drugs like painkillers, muscle relaxants and steroids). It does not contain records about other prescription drugs like antibiotics, antidepressants, or any other category of prescription medication.

Only authorized individuals, like healthcare personnel that prescribe controlled substances and law enforcement under very limited circumstances, can access the database and only for tightly defined uses. As long as you are using controlled drugs appropriately, there shouldn't be reason for concern. If you do not want your information in the database, please ask your dentist to prescribe non-narcotic drugs for you.

More information about Colorado's prescription drug monitoring program, including copies of individual prescription drug records stored in the database, can be obtained from the Colorado state Department of Regulatory Agencies by calling 303-894-5957 or by visiting http://www.dora.state.co.us/pharmacy/pdmp/consumers.htm.

I have read and understand this notification.

Signature of patient/guardian _____ Date _____

If this notification is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

_____

Relationship to Patient:

_____

Teresa M. Lowery, D.D.S., P.C - 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 here in the office.

Our legal dub'

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect on April 14, 2003, 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. We reserve the right to maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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 the Practice Administrator listed at the end of this disclosure.

Uses and Disclosures of health information.

We use and disclose health information about you for treatment, payment, and operations. For example:

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

Payment: We may use or disclose your health information to obtain payment for services we provide to you. For us to electronically submit any claims on your behalf to your insurance company, we must have your written permission.

Signature: _____

Date: _____

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities. However, nothing in this section requires non-licensed individuals to oversee, supervise or dictate the professional activities of duty licensed dental professionals.

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.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we Will provide you with disclosing 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 institutions or law enforcement officials having lawful custody of protected health information inmates or patients under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, automatic reminder text , e-mail, postcards, or letters).

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 any form other than photocopies. We will use the format you request unless we cannot practically do so. We will email or mail out your records. (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. You may also request access to sending us a letter to the address at the of this Notice If you request an alternative format. If you prefer, we will prepare a summary of an explanation of our fee structure**.**
(Contact us using the information listed at the end of the Notice for a full explanation of our fee structure).

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 April 14, 2003. If you request this accounting more than once in a 12- month period, we will charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

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 locations and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request 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.

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 by alternative means or at alternative locations, you may express such concerns 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 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 Officer: Juliet To
Telephone: 303-753-0922
Address: 425 S. Cherry st., Suite 210, Denver, CO 80246

Payment Policy

Agreement: My written, verbal, or implied consent to pay for treatment is binding when I allow treatment to be performed. I agree to pay all billing fees, collection agency fees, and attorney fees which may result when my account is past overdue.

This office has my authorization to charge insurance EOB balances to my payment method on file, should the insurance company increase my patient balance higher than the standard "guesstimated" provider. I authorize payment transactions by virtual terminal, payment method on file, or text to pay, to satisfy the outstanding account balances and I acknowledge that I understand and agree to the financial payment policy of My Cherry Creek dentist with Dr, Lowery and have had all my questions answered and give consent to collect payment for the procedures received by myself, or by those for whom I am the Responsible party. I have had the full opportunity to read and consider the contact of this entire document. I understand that I am giving my permission for the use and disclosure of my protected health information to carry out treatment, payment activities, collection activities and healthcare operations.

Patient Signature:_____ **Date:**_____

Insurance and Reimbursement:

A credit card or debit card on file is required for us to file a courtesy insurance claim on your behalf and wait for an "guesstimated" payment (assignment) or denial from your dental insurance plan. Please give your medical and dental insurance card to the front office coordinator and after your visit please let us know what card you'd like to have on file as payment.

You are 100% responsible for all fees for all services that you or your dependent(s) receive at My Cherry Creek dentist.

- By electing to have My Cherry Creek dentist file a dental insurance claim on your behalf and accept assignment of benefits you also authorize the following: Outstanding patient responsibility for the service and other outstanding balances, will be charged to the payment method on file: if applicable this will happen on the same day the EOB is posted to your account. If our "guesstimate" of your patient responsibility was high, the card on file will be credited with the difference.
- If you prefer not to allow secure storage of a payment method on file by our payment policy processor, then you pay in full on the date of service, and we will assist you with filing for direct reimbursement from your insurance company.

- Your insurance company will give you an EOB from the date of service, with breakdowns of what is the covered benefit and what you owe. Please contact your insurance plan with any claim questions. Secondary insurance may be filed as a courtesy, and any payment approved by your plan will be remitted directly to you by your plan.