Health Partners of Western Ohio

# Dental Outreach Consent Form

## PLEASE SIGN AND RETURN TO SCHOOL

Our Outreach Team will be coming to your school and offering dental services. Regular dental check-ups are an important part of overall health. **We will bill Medicaid and Private Insurance.** The dental visit will be considered a preventive visit through your insurance company. If your child has no health coverage there will be NO charge. Our center can help sign you and your family up for insurance, if eligible. The program is open to all children.

**Please check Yes or No and complete the form below:**

☐ **YES,** I give my informed consent for my child to participate in the School-Based Dental Outreach Program. Please complete the rest of this form, **PRINT & SIGN at the bottom** and return it to your child's school.

☐ **NO,** I do not want my child to receive dental services.

Child's First Name: _____ Child's Last Name: _____

Child's Date of Birth: ____/____/____ ☐Female ☐Male Child's SSN: ____-____-____

School Name: _____ Grade _____ Rm # _____ Teacher: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____ County: _____

Race/Ethnicity (Circle all that apply): White Black/African American Hispanic Asian Pacific Islander/ Hawaiian Native American/Alaskan Native Other

Does your child have any serious health problems? ☐Yes ☐ No If YES, please explain: _____

Does your child have any allergies? (i.e.: acrylics/plastics/bees/latex, etc.) ☐Yes ☐ No Please List: _____

## Insurance Information

### Medicaid Plans

Circle plan your child has and fill in Billing Information

Humana | buckeye health plan | CareSource | UnitedHealthcare | MOLINA HEALTHCARE | Anthem | AmeriHealth Caritas | Other Medicaid

Member ID # _____

Medicaid # (MMIS) _____

### Private Insurance Plans

If your child has private insurance please fill in Billing Information

Name of **Dental** Plan: _____

ID # _____

Group # _____

Insurance Holder Name: _____

Insurance Holder DOB: _____

Insurance Holder SSN: _____

Claim Address: _____

Phone # _____

Employer: _____

I have read and completed the information on this consent form and my signature below gives consent for treatment and is valid for the life of the student. I have read and understand the Notice of Privacy Practices on the back of this form and know that a copy is available from the school office or hpwohio.org. This form, when signed and filled in, contains Protected Health Information and the information is to be protected according to the Health Insurance Portability and Accountability Act. I authorize Health Partners staff to provide dental at school to the above named child. The dental services include an exam, cleaning, fluoride, sealants, and the application of Silver Diamine Fluoride as needed. (The use of Silver Diamine Fluoride may discolor any cavities to a brown or black color. SEE BACK FOR DETAILS.) I give consent for Health Partners staff to collaborate with school staff especially when additional dental and/or vision treatment is necessary to ensure my student receives follow-up care.

**Parent/Guardian Signature** _____ Date _____

**Print Parent/Guardian Name** _____

**To find a medical or dental office near you, please visit our website at www.hpwohio.org or call 567-825-0226. Like us on Facebook!**

2023

# HIPAA Notice of Privacy Practices

**HEALTH PARTNERS OF WESTERN OHIO**

**WE ARE COMMITTED TO PROTECTING THE PRIVACY OF YOUR HEALTH INFORMATION. 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.**

This Notice of Privacy Practices explains how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your care provider or HPWO Pharmacy, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the care provider or HPWO Pharmacy, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your care provider's practice or HPWO Pharmacy. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your care provider. We may also call you by name in the waiting room when your care provider or pharmacist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization,** at any time, in writing, except to the extent that your care provider's practice or HPWO Pharmacy has taken an action in reliance on the use or disclosure indicated in the authorization.

## YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply) –** Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information –** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction.

**You have the right to request to receive confidential communications –** You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information –** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures –** You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and to make new notice revisions effective for all protected health information that we maintain by:

- Posting the revised notice at our facilities
- Making copies of the revised notice available upon request

## CONTACT FOR QUESTIONS OR COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

**Compliance Officer:** Elizabeth West, Health Partners of Western Ohio, 329 North West St. Lima, OH 45801 419-221-3072, ext. 1110.

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.**

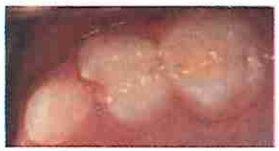
**Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.**



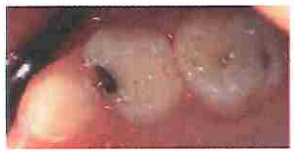
**Silver Diamine Fluoride (SDF) – A new dental treatment to fight cavities**

Dental cavities are very common with children, but now our outreach dental teams have a safe, painless alternative to traditional cavity drilling procedures called silver diamine fluoride (SDF). SDF is an FDA-approved antibiotic liquid used to help prevent cavities from forming, growing, or spreading to other teeth. It is simply brushed on the tooth.

**Without SDF**



**With SDF**



**About SDF:**

- The outreach dental team will use SDF on back teeth only.
- It's normal for SDF to stain the cavity brown or black. This is permanent but can be reversed with a filling or loss of the baby tooth.
- The healthy parts of the tooth will not be stained.
- Further treatment of any dental care needs can be met at our health centers. SDF treatment may not eliminate the need for a traditional filling
- SDF can temporarily stain nearby areas in the mouth. The stain causes no harm and should disappear on its own within a few days to a couple of weeks.
- SDF may cause a temporary metallic taste.