¡EL DENTISTA VIENE A LA ESCUELA!

Cuidar de los dientes de su niño(a) es importante para mantenerlos sanos

Por favor llene, firme y regrese a su maestro(a) en 2 días

¡Incluye atención dental inicial y visitas de seguimiento!

1. DIGANOS ACERCA DE SU NIÑO(A)

Si su hijo(a) ya visita un dentista regularmente, continúe con ese dentista.

Escuela o Nombre del Programa______________________________ Condado______________

Profesor______________________________ # de Salón________Grado________ AM/PM

Nombre Legal del Niño(a)______________________________ Fecha de Nacimiento__________ Hombre/Mujer (circule uno)

Seguro Social ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Padre/Tutor Legal______________________________
ESCRIBA CLARO Y FIRME ABAJO)

Dirección______________________________Ciudad/Código Postal______________________________

Email______________________________ Teléfono (   )______________ Teléfono Alt. (   ) ______________

2. INFORMACION DEL SEGURO

MEDICAID Y HEALTHY START/HEALTHY FAMILIES CUBREN 100% DEL TRATAMIENTO

☐ NIÑO(A) TIENE MEDICAID/HEALTHY START/HEALTHY FAMILIES — Circule uno de los siguientes: **Medicaid, CareSource, United Healthcare, Buckeye, Molina, Paramount, Otro:**______________________

Escriba el numero de identificación del niño(a) AQUÍ → ______________________________

☐ NIÑO(A) TIENE SEGURO DENTAL PRIVADO

Nombre de la Comp. de Seguro (aparte de Medicaid)______________________ Tel. del Seg.______________

Grupo______________________Empleador______________________Tel. del Empleador______________

Nombre del Adulto Asegurado______________________ **FECHA DE NACIMIENTO del adulto Asegurado** __________

Póliza/ID______________________ Seguro Social del Adulto Asegurado______________________

DOBLE — DOBLE

☐ NIÑO(A) NO TIENE SEGURO DENTAL **Si va a pagar por los servicios, por favor haga su cheque o giro postal a Smile Care, LLC y engrápelo a esta forma.**

☐ Puedo pagar el costo completo por la limpieza, revisión y fluoruro por visita. Edad 13 o menor: **$137.00** Edad 14 o mayor: **$146.00**

☐ Certifico que necesito pagar por servicios subsidiados por que no puedo pagar el costo completo. Cubrirá la limpieza, revisión y fluoruro por visita. Edad 13 o menor: **$43.00** Edad 14 o mayor: **$54.00**

☐ Certifico que no puedo pagar por el costo completo o subsidiado y pido asistencia financiera completa la cual cubrirá la limpieza, revisión y fluoruro (ayuda donada está disponible para tratamiento de restauración). Le enviaremos una solicitud por correo. Ayuda disponible solamente una vez por año escolar.

3. HISTORIA MEDICA DEL NIÑO(A)

Notifíquenos de cualquier cambio en el historial medico.

UNICAMENTE SELECCIONE LA CONDICION(ES) QUE APLIQUE(N).

☐ Problemas dentales recientes
☐ Celula de la Hoz
☐ Asma o problemas de respiración
☐ Anemia/Ataques epilépticos /Desmayos
☐ Problemas de comportamiento
☐ Problemas del Riñon
☐ Enfermedades Transmisibles/TB
☐ Problemas del Hígado/Hepatitis
☐ Fiebre Reumática
☐ VIH/SIDA
☐ Diabetes
☐ Cáncer
☐ Hemofilia o problemas de sangrado
☐ Problemas del Corazón. Describa ______________________

Liste alergias (incluya alergias a algún medicamento)______________________

Nombre y # de Teléfono del Doctor______________________

____

Use el espacio de abajo para darnos información adicional sobre la salud de su niño(a), incluyendo cualquier tratamiento que este recibiendo, alguna otra enfermedad de significado, uso de alcohol o tabaco (incluyendo el que no se fuma). Liste todos los medicamentos que esta tomando. Adhiera otra página si es necesario.

____

Fecha aprox. de la ultima visita dental ____________

☐ **MARQUE SI REQUIERE ANTIBIOTICO ANTES DE OBTENER TRATAMIENTO DENTAL**

4. LEA Y FIRME ABAJO

Solicito que el dentista realice una revisión de cuidado dental preventivo a mi hijo(a) la cual cubrirá el examen dental, limpieza, fluoruro, sellantes, y rayos-x como sea necesario. Este permiso incluye visitas al dentista en el futuro. He leído la ADVERTENCIA IMPORTANTE Y CONSENTIMIENTO EN LA PARTE POSTERIOR DE ESTA PAGINA, entiendo y estoy de acuerdo con sus términos.

OFFICE USE ONLY		
1st	6 mo	
		exam, prophy, fluoride
		exam, prophy
		(4)bwx or (2)bwx
		PA films for diagnosis
		seal perm molars
		csf

FIRME Y FECHA AQUI ______________________________ ____________
FECHA

OH-PREVE-008-V2 6/14

Preguntas: 1-888-833-8441 Fax:1-888-330-4331 Visítenos en: mobiledentists.com

Para su privacidad doble y asegure.

Elliot P. Schlang, D.D.S., General Dentist & Dental Director, Smile Care LLC, 6725 W. Central Ave., Suite M #111, Toledo, OH 43617

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IMPORTANT NOTICE & CONSENT / AVISO IMPORTANTE Y CONSENTIMIENTO

I understand and authorize Smile Care, LLC (Provider) and its affiliated dentists to provide the following services for the named child for whom I am the custodial parent or legal guardian: dental exam, teeth cleaning, fluoride treatment, x-rays & dental sealants. While it is unlikely your child could be harmed by preventive dental care, in rare cases, the products we use may cause allergic reaction. (For additional information regarding the benefits and risks of preventive dental care, please call the number provided.) I authorize & direct Provider to bill & collect payment from any Medicaid, insurance, or other payor. If I have private dental insurance, I will be billed for & agree to pay any deductibles and/or co-pays. Treatment by the in-school dentist may affect future benefits that your child may receive under private insurance, Medicaid or CHIP. Unless I have made pre-arrangements to attend, and am there at the time of service, services will be provided without my presence. We may send you text messages about the school dental program. Message and/ or data fees may be charged by your wireless service provider; to discontinue, reply "STOP" to any message received from us. You also agree to receive pre-recorded and/or auto-dialed telephone calls relating to the school dental program at the land-line and/or mobile telephone numbers provided on this consent form. I have received the Notice of Privacy Practices (NPP) attached to this form and consent to the release of my child's medical record information, including records obtained from other providers, and any HIV/ AIDS, communicable disease, sexually transmitted disease, drug and alcohol, and anemia information. I authorize release of such information by Provider to any responsible payor and/or administrative service provider and their subcontractors for use and disclosure relating to my child's treatment, payment for services and health care operation purposes. This signed consent authorizes my child's initial and future dental visits. I may withdraw this consent at any time in writing.

Entiendo y autorizo a Smile Care, LLC (Proveedor) y a sus dentistas afiliados a proveer los siguientes servicios al niño(a) mencionado del cual soy el padre custodio o tutor legal: examen dental, limpieza de los dientes, tratamiento de fluoruro, rayos-x y sellantes. A pesar de que no es probable de que su niño(a) sea dañado durante los cuidados dentales preventivos, en raras ocasiones, los productos que utilizamos pudieran causar una reacción alérgica. (Para más información sobre los beneficios y los riesgos del cuidado dental preventivo, por favor llame al número proporcionada.) Autorizo y dirijo al proveedor a facturar y recolectar pago de Medicaid, seguro privado o tercera persona. Si tengo seguro dental privado, seré facturado y acuerdo a pagar cualquier deducible y/o co-pago. El tratamiento realizado por el dentista escolar pudiera afectar los beneficios de su niño en un futuro bajo su cobertura privada, Medicaid o CHIP. Al menos de que allá hecho algún arreglo previamente para atender y estoy ahí al momento de los servicios, el servicio será proveído sin mi presencia. En ocasiones podremos mandarle un texto sobre el programa dental escolar. Cobros de mensaje o/y de datos pueden ser aplicados por su proveedor de servicios inalámbrico; para descontinuar, responda "STOP" a cualquier mensaje que reciba de nosotros. Usted también acepta recibir transmisión pre grabada y/o auto llamadas telefonicas relacionadas con el programa dental escolar a los numeros telefonicos que usted proporciono en esta forma de consentimiento. He recibido el Aviso de Prácticas Privadas (NPP) adjuntas a este formulario y el consentimiento para la divulgación de la información y/o expediente médico de mi hijo(a), incluyendo los registros obtenidos de otros proveedores, y cualquier otra enfermedad como: VIH/SIDA, enfermedades contagiosas, enfermedades de transmisión sexual, drogas, alcohol, y anemia. Yo autorizo la divulgación de dicha información por parte de proveedores para cualquier pagador responsable y/o proveedor de servicios administrativos y de sus subcontratistas para el uso y divulgación de información relacionada con el tratamiento de mi hijo(a), pago para el mantenimiento y operación de cuidado dental. Esta forma de consentimiento firmada autoriza la visita dental inicial y visitas de seguimiento. Puedo retirar mi consentimiento en cualquier momento por escrito.

KEEP FOR YOUR RECORDS

ELLIOT P. SCHLANG, DDS - GENERAL DENTIST, DENTAL DIRECTOR

General Dentists - Brenda Bailey, DDS, Dennis Baum, DDS, Ayah Bilbeisi, DDS, Karyn Boltz, DDS, Roger Bryant, DDS, John Dokler, DDS, Robert Dycman, DDS, Dwight Fox, DMD, Judy Gerson, DDS, Anne Gormley, DDS, Robert Hamann, DDS, Ralph Meluch, DDS, Aubrey Morek, DDS, Joe Patton, DDS, William Schmerge, DDS, J. Dale Smith, DDS, Daniel Soucie, DDS.

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. KEEP FOR YOUR RECORDS

OUR LEGAL DUTY

The privacy of your medical information is important to us. 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. We will notify you if your unsecured medical information is breached.

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 make the changes in our privacy practices and the new terms of our Notice effective for all health information that we 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 us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

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

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our business operations such as reviewing the competence or qualifications of healthcare professionals and evaluating practitioner and provider performance.

Your Authorization: Uses or disclosures not otherwise described in this Notice may be made only with your written authorization. In addition, we must obtain your written authorization to sell your medical information or to use or disclose your information for marketing goods or services to you where we are paid to make the communication. 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 and Persons Involved in Your Care: We may disclose your health information to a family member, friend or other person involved in your care to the extent necessary to help with your healthcare or with payment for your healthcare. We may also disclose your medical information to disaster relief organizations to help locate individuals during a disaster. We may also use or disclose your medical information to notify, or assist in the notification, of a family member, a personal representative or a person responsible for your care of your location, general condition or death. If you do not want us to disclose your medical information to family members or others in these circumstances, please notify our HIPAA Officer at 623-434-9343 x1152

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

Public Safety: We may need to disclose medical information to law enforcement officials, such as in response to a search warrant or a grand jury subpoena, or to assist law enforcement officials in identifying or locating an individual, to report deaths that may have resulted from criminal conduct, and to report criminal conduct on our premises.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a 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 your medical information to military authorities of Armed Forces or foreign military personnel under certain circumstances; to authorized federal officials for lawful intelligence, counterintelligence, or other national security activities, and to protect the president; and to a correctional institution or law enforcement official having lawful custody of an inmate or patient under certain circumstances.

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

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure surveys. These activities are necessary for the government to monitor the health care system, the outbreak of disease, government programs, compliance with civil rights laws and to improve patient outcomes.

Lawsuits and Disputes: We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process.

Other Uses and Disclosures. As permitted or required by law, we may use or disclose your medical information for research purposes; to organizations that handle and monitor organ donation and transplantation; for workers' compensation or similar programs to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness; for public health activities such as to prevent or control disease, injury or disability; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to, or is at risk for contracting or spreading, a disease; to medical examiners to identify a deceased person or determine cause of death; or to funeral directors to carry out their duties.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information and fax your request to the number at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of some disclosures we or our business associates have made of your health information. 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.

Restriction: You have the right to request that we restrict our use or disclosure of your health information. We are not required to agree to your request except when disclosure would be to your health plan, you (or someone on your behalf other than your health plan) has paid in full for your health care, the disclosure relates to payment or health care operations, and the disclosure is not otherwise required by law. If we agree to the restriction, however, we will abide by that agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations specified in your written request.

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

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are con-cerned that we may have violated your privacy rights, 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 not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: HIPAA Officer

Phone: 623-434-9343 x1152

email: hipaaofficer@smileprograms.com

Effective Date: August 1, 2013