Does your child need a dentist?

The UK College of Dentistry is coming to your child's school this year!

The UK Dental Team will see each child who completes the consent forms attached. The services are provided at no cost to you. Services provided to your child may be billed to dental insurance companies such as Medicaid, KCHIP, and Kentucky's Managed Care Organizations. If you have private dental insurance, please use a local dentist who accepts your dental plan.

Each eligible child will receive a dental exam, cleaning, fluoride treatment and sealants. A dentist will see your child at least one time during the school year. A dental hygienist may provide services without the dentist present. A vitamin for the teeth, called a fluoride varnish, is applied at each visit. Fluoride can slow down the cavity process or may even reverse the disease. A dental sealant can help prevent cavities on permanent molars. It is a plastic material that fills in the grooves on molars. The best way to prevent cavities is with great home care! Our Dental Team also teaches children how to properly brush, floss, and choose healthy foods and drinks!

A dental report card is sent home after each visit. Each report card tells what services were received that day and if your child needs to see a dentist for treatment. Dental x-rays are not taken at the school. Not all cavities can be found by an exam alone. Your child may benefit from having x-rays taken at a dental office. If your child sees a dentist twice a year already for cleanings, the dental program may interfere with the care they are currently receiving from their dentist. We look forward to working with your family to improve your child's oral health!

> If you have a dentist that your child sees every 6 months for preventive dental office visits, please DO NOT use this program to replace your child's visit to your family dentist.

Outreach providers

Dr. Laura Hancock Jones

Brenda Law, RDH

Sara Womack, RDH

UK Dan A. Martin MD Dental Clinic

412 N. Kentucky Ave. Madisonville, KY 42431

270-452-2553 clinic

270-452-2555 fax

Keep this top sheet for your information!

- ❑ University of Kentucky Hospital A.B. Chandler Medical Center
- ❑ UK HealthCare Good Samaritan Hospital
- ❑ UK HealthCare Ambulatory Services

Notice of Privacy Practices

Effective April 14, 2003
Revised November 2011

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

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

We are committed to protecting the privacy of all health information we create and maintain as a result of the health care we provide you. Your "protected health information" (PHI) includes information about your past, present or future health, health care we provide you and payment for your health care contained in the record of care and services provided by University of Kentucky health care facilities. The purpose of this Notice is to explain who, what, when, where, and why your PHI may be used or disclosed, and assist you in making informed decisions when authorizing anyone to use or disclose your PHI.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- To request in writing to the treatment area a restriction on the uses and disclosures of PHI as described in this Notice. We are not required to agree to the restriction you request. We may not be able to comply with your request in certain situations, which include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services and uses and disclosures that do not require your authorization.
- To obtain a paper copy of this Notice and upon written request submitted to the UK health care facility maintaining the record, inspect and/or obtain a copy of your health record.
- To amend your health record by submitting a written request with the reasons supporting the request to the Medical Records department. We may deny your request if a) the record was not created by us, unless the person that created the record is no longer available to make the amendment; b) the record is not part of the health information used to make decisions about you; c) we believe the record is correct and complete; or d) you would not have the right to inspect and copy the record as described herein.
- To request in writing to the Privacy Officer a written list of disclosures we made of your health information, except that we are not required to account for disclosures for purposes of treatment, payment, operations, directory notification, disaster relief, as allowed under certain circumstances by law or pursuant to your authorization.
- To request in writing to the treatment area that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter or telephone.
- To revoke your authorization to use or disclose PHI at any time except, unless your authorization was obtained as a condition of obtaining insurance coverage, and except to the extent your PHI has already been disclosed pursuant to your authorization. Your revocation request must be made in writing to the Medical Records unit of the facility where you originally filed your authorization.

OUR RESPONSIBILITIES We are required by law to:

Maintain the privacy of your PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.

Abide by the terms of the Notice currently in effect. We have the right to change our Notice of Privacy Practices and we will apply the change to all of your PHI, including information obtained prior to the change.

Post notice of any changes to our Privacy Practices in the lobby and make a copy available to you upon request.

CONTACT FOR QUESTIONS/COMPLAINTS/REQUESTS

Direct your questions, complaints and requests made pursuant to this Notice to: **Privacy Officer, Privacy Officer, 2333 Alumni Dr., Suite 200, Lexington, KY 40517, (859)323-1184 or (859)323-8002.** You may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI for the following purposes:

Treatment: We may use and disclose your PHI to anyone involved in the provision of health care to you, including for example, University physicians, nurse practitioners, nurses and other medical professionals, including our medical students, residents and volunteers. We may also disclose your PHI to outside treating medical professionals and staff as deemed necessary for your health care.

Payment: We may use and disclose your PHI to billing and collection agencies, insurance companies and health plans to collect payment for our services.

Health Care Operations: We may use and disclose your PHI for our own health care operations. For example, we may use your PHI to assess your care in an effort to improve the quality of our service to you; to evaluate the skills, qualifications and performance of our health care providers; to provide training programs to students, trainees and other health care providers. In addition, our accountants, auditors and attorneys may use your PHI to assist our compliance with applicable law.

Business Associates: There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.

Individuals Involved With Your Care: We may disclose your PHI to family or others identified by you or who is involved in your care or payment for your care. We may also notify a family member, or another person responsible for your care, about your location and general condition, unless you object by contacting the caregiver at the facility providing your care.

Legally Required Disclosures & Public Health: We may disclose PHI as required by law, including to government officials to prevent or control disease, to report child, adult or spouse abuse, to report reactions or problems with products, and to report births and deaths.

Health Oversight Activities: We may disclose your PHI to a federal or state health oversight agency that is authorized to oversee our operations.

Workers Compensation: We may disclose PHI for workers compensation or similar programs.

Serious Threats to Health or Safety: We may disclose PHI if necessary to prevent or reduce the risk of a serious or imminent threat to the health or safety of an individual or the general public.

Law Enforcement & Subpoenas: We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.

Inmates: We may disclose your PHI to a correctional facility which has custody of you if necessary a) to provide health care to you; b) for the health and safety of others; or, c) for the safety and security of the correctional facility.

Information Regarding Decedents: We may disclose health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donation.

Research: We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or an institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information. In all other situations, we may only disclose PHI for research purposes with your authorization.

Marketing & Fund Raising: We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also contact you as part of a fund raising effort.

Directory Information: We may disclose your name, location and general condition to those persons who ask for you by name or to members of the clergy. You may object to such disclosure by contacting the Registration Office/Desk at the facility from which you received this Notice.

Appointment Reminders: We may use and disclose your PHI to provide a reminder to you about an appointment.

Treatment Alternatives: We may use and disclose your PHI to contact you about treatment alternatives that may be of interest to you.

DISCLOSURES REQUIRING AUTHORIZATION

All other disclosures of your PHI will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already made disclosures pursuant to your authorization.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all PHI that we maintain by posting the revised Notice at our facilities, making copies of the revised Notice upon request to the facility or the Privacy Officer, or posting the revised Notice on our website.

2016-17 University of Kentucky College of Dentistry Prevention Consent Form

Child's Name: Last: ____________________ First: _______________Middle:_________ Preferred Name: _________________

Gender: ☐ Male ☐ Female Child's Date of Birth: ____/_____/________ Child's Social Security #: _________________

School_______________________________Grade:_________Teacher:____

Parent/Guardian's Name: ____________________________________Relationship to Child: _________________________

Parent/Guardian's Phone Numbers: Home: ____________________Cell:___________________ Work: ________________

Mailing Address: __________________________________City:_____________________State:_____ Zip code: _________

Parent/Guardian Email: __________________________________ Main Language Spoken in Home: _____________________

Which of the following best describes your child? (Optional) ☐ White ☐ Black/African American ☐ Multiracial

☐ Hispanic/Latino ☐ Asian/Pacific Islander ☐ American Indian or Alaskan ☐ Other________________________

WHAT ADULT CAN WE CONTACT IN CASE OF AN EMERGENCY **OTHER THAN GUARDIAN LISTED ABOVE**?

Name: ________________________ Relationship to the Child: ________________ Phone # ________________

INSURANCE SECTION: Is your child covered by any dental benefits/dental insurance programs? ☐ Yes ☐ No

If yes, check below:

☐ Medicaid/KCHIP # ____________________

☐ Private (write-in) Private Dental Insurance Name: _______________________ **(example: delta dental)** ID # _______________

MEDICAL HISTORY SECTION:

Does Child have, or has your child ever had any of the following:		
Diabetes	YES	NO
Heart Problems	YES	NO
Artificial heart valve:	YES	NO
Heart Surgery Date:_____/_____/_______	YES	NO
Asthma	YES	NO
Hemophilia or bleeding problems	YES	NO
Epilepsy (seizures)	YES	NO
Intellectual, Developmental, or Behavioral Disorders (including: ADHD, ADD, Autism)	YES	NO
Tuberculosis (TB)	YES	NO
GERD (stomach acid reflux)	YES	NO
Allergy to Latex	YES	NO
Allergy to Medications (including Penicillin, sulfa, or other antibiotics)	YES	NO
History of Surgery	YES	NO
Any Serious Health Problems (cancer, HIV/AIDS, etc)	YES	NO

If YES to any questions, please explain:

Is your child supposed to take medicine (antibiotics) before having dental care? ☐ **YES** ☐ **NO**

If YES, Why?

____

Is your child taking ANY medications now for any reason?

Yes No If yes, please list all medicine your child takes:

____

____

For what illness?

Who is your child's Primary Care Doctor or Nurse?

________________________________ **Phone:** _____________

What drug store do you go to when you need medicine?

________________________________ **Phone:** _____________

Who is your child's Dentist?

________________________________ **Phone:**_____________

UK Office Use Only

ASA I ASA II Date: ____________ Pt. #_______________

Reviewed by: ____

University of Kentucky College of Dentistry Dental Outreach Programs 2016-17

Child's Name: ________________________________ **Child's Date of Birth:** ____/_____/_______ **School:** _______________________

By signing this consent, I give permission for the following:

I give consent for my child, if eligible, to be examined and treated by the University of Kentucky dental staff and students with the Dental Mobile Outreach Program. **I understand** that I am authorizing the rendering of diagnostic and treatment procedures. Procedures include: clinical exams, fluoride treatment, sealants and cleanings by authorized agents and employees of the University of Kentucky, College of Dentistry, The Chandler Medical Center, and the dental staff, or their designees, as may in their professional judgment be deemed necessary or beneficial; and may include testing for strep mutans (the bacteria that causes tooth decay) and any other bloodborne diseases. All diagnostic aids are the property of the College of Dentistry. I understand that certain risks and complications may happen if my child has these procedures. These possible problems include: The possibility of discomfort during and following treatment, aspiration or swallowing a dental instrument or dental material, allergic reactions to dental materials, and other possible problems that the dentist cannot predict.

- *I understand* that these services will be provided by the dental faculty, residents, students, hygienists and staff of the University of Kentucky and that a dentist faculty member from the University will provide coordination of the program.
- *I understand* that the preventive treatment (cleaning, fluoride and sealants) may be provided by a registered dental hygienist without the presence of the dentist, as outlined in general supervision legislation.
- *I understand* that the dental findings for all the children as a group may be reported on and/ or published, and that, in this case, no child will be identified individually. While all the individual records are held by the University of Kentucky as confidential, I understand that a list of children who need follow-up dental treatment is routinely provided to the Family Resource Center.

Permission to Communicate: There may be a need to communicate with you or the emergency contact provided above concerning your child's medical history, treatment or oral health needs.

- *I understand* that I am giving you permission to communicate with me or the emergency contact provided above through written notes sent home with my child; voice mail left on home answering machine or cell phone; email and/or text messages.

Release of Information: Authorization is granted to the College and its staff to release pertinent information from the patient's record to any insurance company or agency which is legally responsible for all or any part of the College's service fees for the treatment rendered. It is understood that release of information for any other reason than that necessary to secure payment for services rendered requires an additional authorization from the patient's parent or guardian.

Payment Authorization: I hereby authorize payment directly to the University of Kentucky of the insurance benefits otherwise payable to me, unless special arrangements are made.

Receipt of Privacy Practices

I understand that as part of my healthcare, University of Kentucky and its affiliates originates and maintains health records. These health records describe my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- **A basis for planning my care and treatment**
- **a means of communication among the many health professionals who contribute to my care**
- **a source of information for applying my diagnosis and medical treatment information to my bill**
- **a means by which a third-party payer (i.e. insurance company) can verify that services billed were actually provided**
- **and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals**

The University of Kentucky and its affiliates' Notice of Privacy Practices gives a more complete description of how my health information may be used or disclosed. The notice also explains my rights regarding my personal health information is used or disclosed. I understand it is my responsibility to notify University of Kentucky and its affiliates regarding any restrictions to disclosure of my health information regarding this or any subsequent visit.

I give my consent for my child, if eligible, to be examined and treated by the University of Kentucky dental staff of the Dental Mobile Outreach Program as described above. I have also been provided with a ***Notice of Privacy Practices*** *(see back of cover letter)* and I have been given the opportunity to review this notice.

X__________________________________ ____ **Date:** ______________

Parent/Guardian Signature **Print Name of Parent/Guardian**