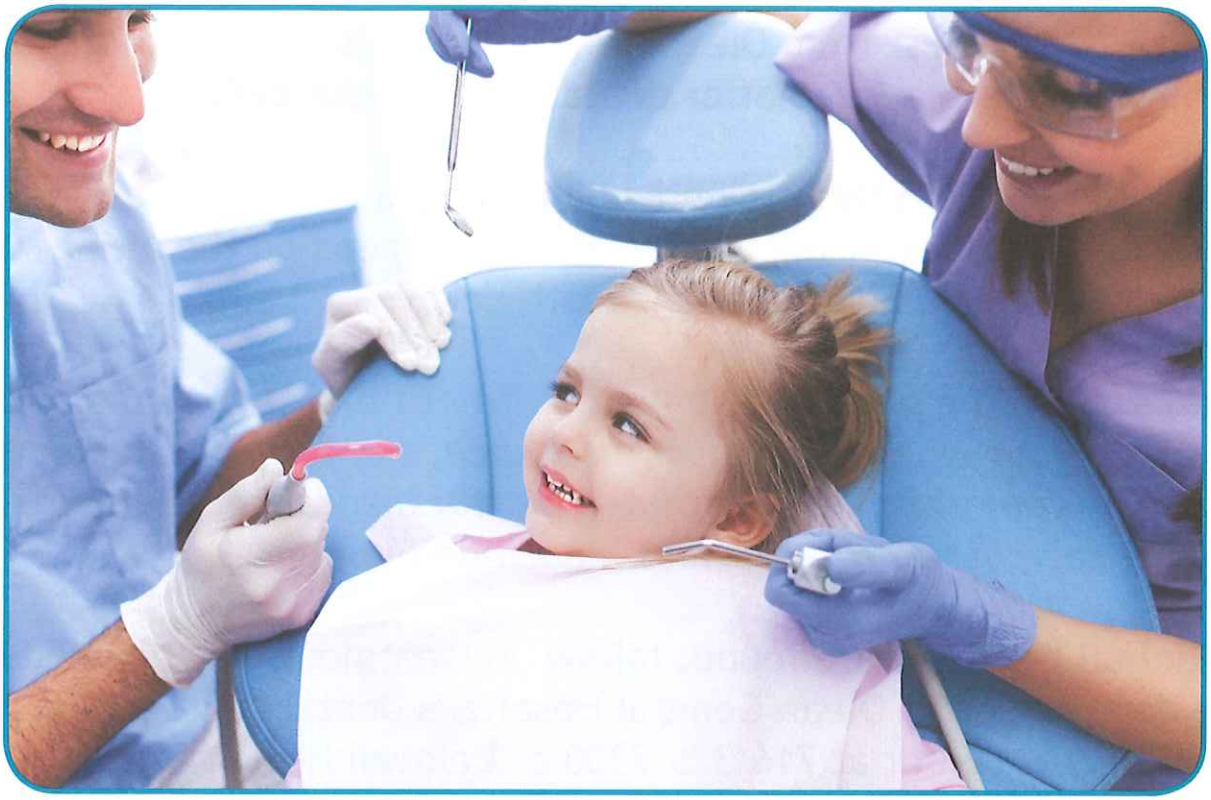
## Wellsville Central School's Sealant Program



# Great dental care is coming to your school

## Please see letter inside with forms to return to school.

## Start dental care early.

Services provided by:

Olean General Hospital
GUNDLAH DENTAL CENTER

Olean General Hospital Campus
623 Main Street, Olean, NY
716-375-7300

Delevan Health and Dental Center
OLEAN GENERAL HOSPITAL

Delevan Plaza
38 N. Main St, Delevan, NY
716-707-7040

Dear Parent(s) or Guardian:

A dentist and hygienist from Olean General Hospital's Sealant Program will be coming to your school to offer dental care to your child.

Children who enroll in this program will receive an exam, a fluoride treatment and possibly sealants. Sealants are placed on the biting surface of permanent teeth to help prevent tooth decay.

***Dental care will be provided to your child at no cost to you under this program. If your child has dental insurance, the insurance company will be billed. If your child does not have dental insurance, grant funding will cover the cost of the services mentioned above.***

If any dental problems are found, follow up treatment may be needed. This can be done at one of Olean General Hospital's dental centers. You can call Gundlah Dental Center at 716-375-7300 or Delevan Health Center at 716-707-7040 for an appointment. You may also contact your private dentist.

Due to the school setting, this exam does not include x-rays of your child's teeth. A full exam, including x-rays, is recommended for your child once a year. It is also recommended that children have their teeth professionally cleaned twice a year. This can be done at the Gundlah Dental Center, Delevan Health Center, or a dentist of your choice.

***Please complete the forms and return them by the next school day.*** **For more information, please call 716-375-7529.**

Thank you,

Colette Perkins

Colette Perkins
Practice Manager, Dental Centers

# Wellsville Central School's Sealant Program
# Child's History Form

Please Complete All Information Below

**Please Print Clearly** Today's date: _____

**Child's Name** _____ ☐Male ☐Female Date of Birth: _____

**What is your relationship to the child?**_____

**DENTAL HISTORY**

When was their last dental cleaning, exam, or x-rays? _____

Have they ever had complications with previous dental treatment? If yes, please explain: _____

Do they have anxiety in regards to Dental Treatment? _____

Does anyone in your family have: ☐Periodontal Disease ☐Dentures or Partials?

Does your child take Fluoride treatments at home or in school? ☐Yes ☐No ☐Does not apply

Do you have well water? ☐Yes ☐No

**MEDICAL HISTORY**

Primary Care Doctor:_____ Date of last visit: _____

Please check any of the following they may have or have had

☐ Anemia
☐ADHD
☐Arthritis, Rheumatism
☐Artificial Heart Valves
☐Artificial Joints/Pins/Screws
☐Asthma
☐Back Problems
☐Chemo/Radiation
☐Congestive Heart Failure
☐Cancer
☐Chemical Dependency
☐Clotting Problems
☐Diabetes: Type: _____
☐MRSA
☐Heart Murmur
☐Heart Attack/Surgery
☐Hepatitis: Type _____
☐Herpes
☐Hemophilia
☐HIV/AIDS
☐High Blood Pressure
☐Jaw Pain
☐Kidney Problems
☐Liver Problems
☐Lupus
☐Mental Health Problems
☐MR ☐mild ☐moderate ☐severe
☐Mitral Valve Prolapse
☐Neurological Problems
☐Pacemaker
☐Respiratory Problems
☐Rheumatic Fever
☐Seizures
☐Sexually Transmitted Disease (if yes, please state below)
_____
☐Sinus Problems
☐Stroke
☐Stents
☐Stomach Problems
☐Thyroid Problems
☐Tobacco Habit
☐Tuberculosis
☐Vascular Shunt
☐Other: _____

**ALLERGIES** (please check)

☐Yes ☐No Aspirin
☐Yes ☐No Codeine
☐Yes ☐No Erythromycin
☐Yes ☐No Latex
☐Yes ☐No Local Anesthesia
☐Yes ☐No Metals
☐Yes ☐No Penicillin
☐Yes ☐No Sulfa Drugs
☐Yes ☐No Zithromax
☐Yes ☐No Red Dye
Other: _____

List any medications and/or vitamins that they are currently taking

_____
_____
_____
_____
_____
_____

**Females:** Pregnant? ☐Yes ☐No Taking Birth Control? ☐Yes ☐No
Due Date? _____
Who is **her** OB/GYN Doctor? _____

Do they Use: ☐Alcohol ☐Illegal Drugs
Are they in recovery for an Alcohol or Drug Addiction? _____

Please note any previous surgeries and/or medical procedures: _____

Patient/Patient Parent or Guardian Signature: _____ Date:_____

Staff Health History review signature:_____ Date: _____

Olean General Hospital

*A Member of Upper Allegheny Health System*

# NOTICE OF PRIVACY PRACTICES

Effective: September 23, 2013

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.

Olean General Hospital and Bradford Regional Medical Center are members of Upper Allegheny Health System. As such, Olean General Hospital is required by law to maintain the privacy of patients' Protected Health Information (PHI) and to provide individuals with the following Notice of the legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice.

Who will follow this Notice?

- All health care professionals, employees, students, volunteers and other personnel from any department authorized to access your medical record.
- Health care providers not employed by Olean General Hospital or its member hospital who are involved in your care (such as physicians).
- Other entities that provide health care services to you in a way that is integrated with our services at one of our member hospitals, and their health care professionals, employees, students, volunteers and other personnel.

How We May Use and Disclose Your Protected Health Information About You

Treatment: We will use health information about you to provide you with medical treatment or services. We will disclose PHI about you to doctors, nurses, technicians, or other personnel who are involved in taking care of you. Different departments of Olean General Hospital may share health information about you in order to coordinate the services you need, such as prescriptions, lab work and x-rays.

Payment: We may use and disclose medical information so that services can be billed. For example, we may need to give information to your health plan about services you received so your health plan can pay us. We may also inform your health plan about a planned treatment to determine whether your plan will cover the treatment.

Health Care Operations: We may use and disclose PHI about you for the purpose of our business operations. For example, we may use PHI to review the quality of our treatment and services, and to evaluate the performance of our staff, contracted employees and students in caring for you.

Business Associates: We may disclose your health information to contractors, agents and other associates who need information to assist us in carrying out our business operations. Our contracts with them require that they protect the privacy of your health information.

Incidental Disclosures: Disclosures of your information may occur during or as an unavoidable result of otherwise permissible uses or disclosures of your health information. For example, during the course of your treatment, other patients in the area may see or overhear discussion of your health information despite using reasonable safeguards.

Patient Directory: While you are a hospital patient, your name, location, general condition (e.g., satisfactory) and your religious affiliation will be included in a patient information directory. Directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may also be provided to members of the clergy of your congregation, even if they don't ask for you by name. We will give you the opportunity to opt out of the directory, unless an emergency situation prevents us from asking you.

Disclosure to Family, Friends or Other: If you do not object, or we reasonably infer that there is no objection, we may disclose PHI about you to a family member, relative, partner, or another person identified by you who is involved in your health care or payment for your health care. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing limited PHI is in your best interest under the circumstances.

Appointment Reminders: We may use and disclose PHI to contact you as a reminder that you have an appointment with us. We may also use and disclose protected health information to give you information about treatment alternatives, or other health care services or benefits we offer.

Fundraising Activities: We may use and disclose your information to raise funds or solicit support for various programs at Olean General Hospital. You have the right to opt out of receiving fundraising communication. If you do not want the hospital to contact you for fundraising efforts, you must notify the Olean General Hospital Foundation, 515 Main Street, Olean, NY 14760 in writing. All reasonable efforts will be made to ensure those patients who do not want to receive fundraising materials will be removed from the fundraising mailing list.

Research: In certain circumstances, we may use and disclose protected health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects are subject to a special approval process by an Institutional Review Board or similar.

As Required by Law: We will disclose protected health information about you when required to do so by federal, state, or local law. For example, we make disclosures when a law requires that we report information to a government agency and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds, or when ordered in a judicial or administrative proceeding.

To Avert a Serious Threat to Health or Safety: We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Under these circumstances, disclosures would only be made to someone who is able to prevent or lessen such harm.

Public health activities: We may disclose medical information about you for public health activities related to prevention or control of disease, injury or disability. For example, we report certain communicable diseases to the Department of Health.

Health Oversight Activities: We may disclose your medical information to health oversight organizations authorized to conduct audits, investigations, and inspections of our facilities.

Organ and Tissue Donation: We may release medical information to organizations that handle organ, eye or tissue donation and transplantation.

Workers Compensation: We may release protected health information about you for workers compensation or similar programs if these programs provide benefits for work-related injuries and illness.

Specific Government Functions: As a member of the armed forces, we may release protected health information about you as required by military command authorities. We may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

Inmates: If you are an inmate of a correctional facility, or under the custody of a law enforcement official, we may disclose to the institution or agents of the institution health information necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order, subpoena or other lawful process.

Law Enforcement: We may release health information in response to a court order, subpoena, warrant, summons or similar process, to identify or locate a suspect, fugitive, material witness, or missing person, about the victim of a crime, about a death we believe may be the result of criminal conduct, about criminal conduct at the hospital, and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Disclosures to Schools: Student immunization information may be disclosed to a school without written authorization if state law requires the school to have immunization records and the patient or personal representative's written or oral agreement is documented.

Shared Health Information System: Olean General Hospital and Bradford Regional Medical Center are member hospitals under the parent company Upper Allegheny Health system and are affiliated entities under HIPAA Privacy Law; §164.105. We maintain PHI about our patients in an electronic medical record that allow, and when required, access PHI for treatment, payment and healthcare operations.

Other Uses and Disclosures of PHI: Most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes

and disclosures that constitute the sale of PHI require your written authorization.

Other uses and disclosures of PHI that are not described above will be made only with your written authorization. If you provide Olean General Hospital with an authorization, you have the right to revoke the authorization in writing at any time. If you revoke the authorization, we will not further use or disclose your health information for the purposes documented on the authorization.

YOUR RIGHTS REGARDING YOUR PHI

Access, Inspect or Copy: You have the right to review and obtain a copy of your protected health information that may be used to make decisions about your care, including your medical and billing records. To inspect or receive copies of your medical information, submit your request in writing to the Health Information Management Department. We may charge a fee for the costs of copying, mailing or other supplies associated with your request for copies. You may not be denied a copy if you are unable to pay. You may request an electronic copy of your record and it will be provided in an electronic format if it is readily producible; otherwise you will be provided with a printed copy.

In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

Restrictions: You have the right to request restrictions on how we use or disclose your health information to treat your condition, collect payment for your treatment or for our health care operations. We are not required to agree to your request. If we do agree, we will fulfill your request unless the information is needed to provide you emergency treatment. You may direct your written request to the Health Information Management Department. You have the right to restrict disclosure of your medical information to your health plan for payment when you make a written request and pay for the service out-of-pocket in full prior to or at the time of the service, or if you make payment arrangements at the time of the service subject to approval of Olean General Hospital that are complied with in a timely manner. We will comply with this restriction unless the disclosure is required by law.

Confidential Communications: You have the right to request that we send information to you at an alternate address or by alternate means (for example, you may wish to be contacted at work rather than at home). This request must be in writing, and should be directed to the area that would handle the communication. You do not need to provide a reason for your request. Reasonable requests will be accommodated.

Accounting of Disclosures: With some exceptions, you have the right to request an accounting of certain disclosures of your PHI. The request should state the time period for which you wish to receive an accounting. This time period should not be longer than six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable fee for responding to these additional requests.

Amendments: If you believe that PHI we have about you is incorrect or incomplete, you may ask us to amend the information, for as long as Olean General Hospital maintains the information. You must provide the request and your reason for the request in writing; requests can be made through the Health Information Management Department. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (a) correct and complete, (b) not created by us, (c) not allowed to be disclosed, or (d) not part of our records. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people and entities you name.

Electronic Notice: You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

Changes to this Notice: We reserve the right to change this Notice. We may make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The current Notice will be displayed and is available to you on our website at www.ogh.org. The original effective date was April 13, 2003.

Breach Notification: You have the right to be notified of a breach of your unsecured protected health information, with a few limited exceptions. A breach is defined as unauthorized acquisition, access, use or disclosure of protected health information in a manner not permitted, unless there is a low probability that the privacy or security of your protected health information has been compromised.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a privacy-related complaint with us send to:
Privacy Officer
515 Main Street
Olean, NY 14760
716.375.6980

All complaints must be submitted in writing. You will not be penalized for filing a complaint.

# *Dental Record Release Authorization*

Wellsville Central School's Sealant Program

Olean General Hospital
GUNDLAH DENTAL CENTER

Delevan Health and Dental Center
OLEAN GENERAL HOSPITAL

If you would like the records from the Wellsville Central School's Sealant Program sent to you or your dentist, please complete this form and sign below.

Child's Name _____ Date of Birth _____/_____/_____

Record#_____ (office will fill in)

I request the Sealant Program to release:

PROGRESS NOTES
OTHER: _____

Send records to:

Parent/Office/Dr _____
Address _____
City _____ State _____ Zip _____
Phone _____

Parent/Office/Dr _____
Address _____
City _____ State _____ Zip _____
Phone _____

Originals will not be given to the parent/legal guardian or patient. Copies will be mailed to the parent/legal guardian/patient or to your dental provider.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____
Relationship to Patient

Cut or tear along dotted line and send form back to school

# Wellsville Central School's Sealant Program

Please complete information below

## Student Information

**Student's Last Name:** _____

**Student's First Name:** _____

**Date of Birth:** _____/_____/_____
*Month Day Year*

**Student's Social Security Number:** _____

**Sex:** ❑ Male ❑ Female Grade _____

**Ethnicity:** ❑ Hispanic ❑ Black ❑ White ❑ American Indian
❑ Asian/Pacific Islander ❑ Other _____

**Student Address:** _____
_____
_____ _____ _____
*City State Zip Code*

**Who is the student's regular dentist?** ❑ **We don't have one**
Name: _____
Telephone: _____
Address: _____
_____

## Parent / Legal Guardian Information

**Mother**
Last Name: _____ First Name: _____
Employer _____

**Father**
Last Name: _____ First Name: _____
Employer _____

**Legal Guardian, If Applicable**
Last Name: _____ First Name: _____
Relationship of legal guardian to student
❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

**Contact Information for parent or guardian**
Home Tel: _____ Work Tel: _____
Cell: _____

**Additional Emergency Contact**
Name: _____
Relationship to Student: _____
Home Tel: _____ Work Tel: _____
Cell:

## Insurance Information

**Does your child have Medicaid?**
❑ No ❑ Yes: Medicaid ID #
_____

**Does your child have Child Health Plus?**
❑ No ❑ Yes: CHP #
_____

**Which Plan?**
❑ Affinity ❑ NYP Community Health Plan
❑ Neighborhood ❑ Amerigroup
❑ HIP ❑ Health Plus
❑ Other:
_____

**Does your child have other insurance?**
❑ No ❑ Yes:

Name & Policy Number
_____

Coverage Number:
_____

Subscriber's Name:
_____

Subscriber's Date of Birth:
_____

Subscriber's Social Security Number
_____

## Parental Consent for the Dental Center Services

I understand that my child will receive an oral health exam, sealants, and a fluoride treatment. My signature provides consent for my child to receive these services provided by the Sealant Program at his/her school. In the event that emergency care is needed please refer to Olean General Hospital Emergency Department or nearest emergency department.

My signature also indicates I have received a copy of the Notice of Privacy Practices.

**X** _____ _____
**Signature of Parent/Guardian** **Date**

Form # 9044