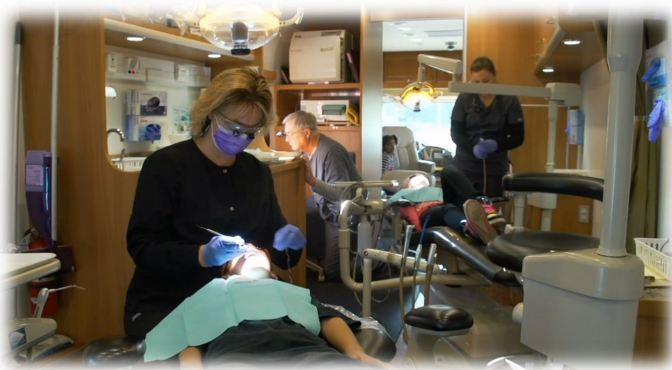
Coming soon to your school!!!

The Bethany for Children & Families

Give Kids a Smile Mobile Dental Clinic

We provide oral health education, dental exam, teeth cleaning, fluoride and sealants if needed. Participants also receive toothbrush/floss.



*****Please fill out the attached permission form CLEARLY, including insurance information and return the <u>second page only</u> to your child's teacher or nurse. *****

If you have any questions please contact your school nurse or the Give Kids A Smile Dental Program Manager, Melody Mosenfelder: Phone: (309) 581-6211 or Email: mmosenfelder@bethany-qc.org

———TEAR OFF AND KEEP THIS PAGE FOR YOUR RECORDS———

GIVE KIDS A SMILE
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.

OUR LEGAL DUTY

Dentists participating in the Give Kids a Smile program may be required by applicable federal and state law to main the privacy of your health information. Protection of patient privacy is important to participants in the Give Kids a Smile program. This notice summarizes the privacy practices that will be followed by participants in the Give Kids a Smile program, and your rights concerning your health information. This Notice will apply to health information collected in connection with the Give Kids a Smile program and will remain in effect until replaced.

You may request a copy of the Notice of Privacy Practices at any time. For more information about the privacy practices, or for additional copies of this Notice, please contact Bethany for Children & Families at (309) 797-7700.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment. For example, we may use or disclose your health information to another dentist, physician, or other health care provider providing treatment to you.

Your Authorization: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. 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.

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 involved in your treatment to the extent necessary to help with your health care.

Persons Involved in Care: 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 use or disclose your health information when we are required to do so by law.

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 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 of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us at (309) 797-7700 for assistance in reaching the dentist or facility holding your health information.

Disclosure Accounting: You may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or certain other activities for the last six years, but not before April 14, 2003.

Restriction: You may 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 may request that we communicate with you about your health information by alternative means or to alternative locations. We may agree to reasonable requests.

Amendment: You may request that we amend 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 & COMPLAINS

If you want more information about our privacy practices or have questions or concerns, please contact us at (309) 797-7700. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your health information, or to have us communicate with you by alternative means or at alternative locations, you may contact us at (309) 797-7700. You may also 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 U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health 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.

———TEAR OFF AND KEEP THIS PAGE FOR YOUR RECORDS———

GIVE KIDS A SMILE — PERMISSION FORM

PLEASE PRINT IN INK & RETURN TO SCHOOL

/ / ☐ M ☐ F

Child's First Name | **Child's Last Name** | **Date of Birth** | **Gender**

Home Address | **City** | **State** | **Zip Code**

Parent/Guardian First Name | **Last Name** | **Phone** | **Email Address**

Emergency Contact Name (If other than Parent/Guardian) | **Relationship to Child** | **Emergency Contact Phone**

Child's School | **Child's Teacher** | **Child's Grade**

☐☐☐☐☐☐☐☐☐

Primary Insurance Provider | **MEMBER ID/INSURANCE#: PLEASE PLACE IN BOXES**

Secondary Insurance (if any): ____

What race do you consider your child?

- ☐ African American / Black
- ☐ White
- ☐ Hispanic / Latino
- ☐ Asian / Pacific Islander
- ☐ American Indian / Native Alaskan
- ☐ Multi-Racial
- ☐ Other ________________

What type of DENTAL INSURANCE does your child have? (check all that apply)

- ☐ Private dental insurance
- ☐ Delta Dental /Hawk-i
- ☐ Medicaid (Medical Card, Title 19)
- ☐ Envolve/Meridian
- ☐ Dentaquest/Molina/BCBS/Aetna
- ☐ Other ___________________
- ☐ None

Please place Medicaid # in boxes above

My child's most recent dental visit was within the past:

- ☐ 0-6 months
- ☐ 1-3 years
- ☐ Never seen a dentist
- ☐ Unsure

Has your child been seen in the Give Kids a Smile Mobile Dental Clinic before?

- ☐ Yes
- ☐ No

For Office Use Only: Found info in: HFS Dentaquest Envolve MCNA Delta Hawk-I other: __________

Verified Insurance Provider/Company (ie. Aetna): __________________________

Last Exam Date: ____/_____/_______ **Sealants: Y or N** **List Date of Sealants & teeth next page**

GIVE KIDS A SMILE — PERMISSION FORM

PLEASE CHECK IF YES

☐ **Needs an antibiotic before a dental procedure.**

☐ Anemia	☐ Nut Allergy
☐ Asthma	☐ Latex Allergy
☐ Bleeding Disorder	☐ Tobacco/drug use
☐ Cancer	☐ Pregnancy
☐ Chronic Sinusitis	☐ Speech Difficulties
☐ Drinks Bottled Water	☐ Fainting/Dizziness
☐ Drinks City Water	☐ Hearing Difficulties
☐ Drinks Well Water	☐ Diabetes
☐ Head Injury	☐ Epilepsy
☐ Heart Condition	☐ HIV/AIDS
☐ **Medication** — Please list	☐ **Concerns with mouth or teeth:**
______________________________	______________________________
______________________________	______________________________

For Office Use Only

Sealants Placed & Date:

☐ 2 ____/____/______
☐ 3 ____/____/______
☐ 14 ____/____/______
☐ 15 ____/____/______
☐ 18 ____/____/______
☐ 19 ____/____/______
☐ 30 ____/____/______
☐ 31 ____/____/______

Health History Reviewed By:

Hygienist's Initials: ____________

Dentist's Initials: ____________

Date: ____________________

PLEASE READ THE CONSENTS BELOW:

I give permission for my child to receive dental treatment and allow the school nurse, school representative, and dental provider to access the child's dental record.

I give permission to Bethany for Children & Families to phone, text and/or email me regarding my child's health services information.

I understand that in the rare circumstance that Bethany for Children & Families needs to transport my child from his/her school to the mobile dental clinic I will be contacted for verbal consent. (There are times that we split the day with a nearby school and your child may need to be transported by an authorized Bethany representative to the location of the mobile dental clinic.)

I give permission for Bethany for Children & Families to release, obtain, or exchange information manually and/or via an electronic platform with the I-Smile Program and/or other dental provider.

I give permission for my child's sealants to be checked and resealed if needed. (These are called IDPH Quality Assurance Audits.) They are performed by professional providers that may need to return to my child's school to recheck his or her sealants and reseal if needed on days that the mobile dental clinic is present.

My signature grants permission for the above consents and authorizes the dental provider to treat and bill for services performed in the mobile dental clinic. I have received a copy of the privacy practices.

Signature for "YES": ______________________________________ **Date:** ________________

Signature for **"NO"**: ______________________________________ **Date:** ________________

Permission and acknowledgment is valid one year from the date of signature.