Smiles of Tomorrow

MOBILE DENTISTRY

Brian Dolive, DDS
Sheryl Handlin, RDH, BAS

Smiles of Tomorrow is coming to your school!

- Dental cleanings, exams, x-rays, fluoride treatments, and sealants done on site
- Local dental professionals from your area
- Maintain healthy and beautiful smiles while keeping your child in school
- No drilling, shots, or needles
- Most insurances accepted (no Medicaid/CHIP)

COMPLETE AND RETURN TODAY

PLEASE RETURN SIGNED FORM WITHIN 2 DAYS

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Preventative treatment may include cleaning, screening, fluoride, exam, sealants, and radiographs.

SIGNATURE REQUIRED - Signed consent includes initial and 6 month visits.

Student Information

School Name_____ County_____ Grade_____ Teacher/Homeroom_____

Student's Legal Name_____ Student's Date of Birth_____ Sex_____

Student's Social Security Number_____ Parent/Guardian (Sign Below)_____

Address_____ Phone/Cell_____

E-mail_____

Health History

Check as "YES" to any conditions that apply to child.

❒ Latex allergy ❒ HIV/AIDS ❒ Diabetes ❒ Hepatitis ❒ Asthma ❒ Seizures ❒ Artificial valves/joints

❒ Chronic sinus/allergies ❒ Mouth breathing

❒ Other Conditions_____

❒ Drug Allergies_____

Current medications_____

Dental problems_____

Date of last dental visit_____ Current Dentist_____

Dental Insurance Information

No Medicaid/CHIP accepted

• Dental Insurance

Subscriber Name_____ Subscriber SSN_____ Subscriber DOB_____

Insurance Name_____ Insurance Phone_____

Group Number_____ Contract Number_____

Employer Name_____ Insurance Address_____

• Private Pay (No insurance or Medicaid/CHIP)

I agree to pay the full fee for a dental cleaning, exam, and fluoride per visit. Sealants are additional and you will be contacted prior to their placement for approval and payment arrangements.

Check/Money Order ❒ **Please make check or money order payable to Smiles of Tomorrow and staple to this form.**

Credit Card ❒

CC Type_____ CC#_____ 3 digit security code (on back)_____ Exp. Date_____

Name as appears on card_____

*****Prices range from $121-220 depending on age, new/returning patient, & need for x-rays. Please call or text 903-241-0061 for exact quote.*****

REQUIRED: Parent Consent/Signature

I am a custodial parent or legal guardian of the minor child listed above. I understand that I am welcome to attend the child's treatment. If not, I authorize an adult school official to accompany the child during any dental visit. The authorized adult may be a school nurse, principal, administrative employee, or an adult named by one of them. I acknowledge that I may be contacted at the address or phone number I provided regarding my child's dental care.

As the custodial parent or legal guardian of the child named above, I authorize Brian Dolive, D.D.S. and his staff to provide dental care which may include cleanings, screenings, fluoride, exams, sealants, and x-rays. I understand that dental care will be provided at school without my presence. No further notification or consent will be provided for provision of dental cleanings, screenings, fluoride, exams, sealants, and x-rays unless I timely withdraw this consent. This signed consent authorizes the initial visit, 6 month visits, and the release of my child's most recent health information as provided to the school. If it is determined upon examination of the child, the need for fillings, crowns, pulpotomies, extractions, or other procedures, the child will receive a written referral for further treatment, except in the case of a medical emergency.

I authorize Brian Dolive, D.D.S. to bill and collect payment from any Medicaid/CHIP, insurance, or other third party payer that covers the services provided to this patient, which will be applied to the patient's benefits. If I have private insurance, I will be billed for and agree to pay any deductibles and/or co-pays. I also acknowledge receiving a notice of privacy practices attached to this consent form. (Please keep the HIPAA privacy form for your records).

By signing below, I legally acknowledge acceptance of these terms and conditions.

Signature of Custodial Parent/Legal Guardian_____ Date_____

If your child has an existing dentist, you may wish to continue dental services with that provider. To avoid dental service or benefit duplication, please inform your dentist which services were provided at school by referring to the oral health report card which will be sent home with your child after the school dental visit.

Brian Dolive, D.D.S., Smiles of Tomorrow, L.L.C., 4 Huntington Circle, Longview, TX 75601, 903-241-0061.

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POR FAVOR DEVUELVA LA FORMA FIRMADA DENTRO DE 2 DÍAS

El tratamiento preventivo puede incluir limpieza, proyección, fluoruro, examen, selladores, y radiografías.

LA FIRMA REQUERIDA - consentimiento Firmado incluye la inicial y visitas de 6 mes.

Información de Estudiante

Nombre Escolar _____ Condado _____ Grado _____ Profesor/Aula _____

Nombre Legal del Estudiante _____ La Fecha de Nacimiento del Estudiante _____ Sexo _____

Número de Seguridad Social del Estudiante _____ Padre/Guardian (Firma Abajo) _____

Dirección _____ Teléfono/Célula _____

E-mail _____

Historia de Salud

Compruebe como 'SÍ' a cualquier condición que se aplica al niño.

❒ Alergia de látex ❒ HIV/AIDS ❒ Diabetes ❒ Hepatitis ❒ Asma ❒ Asimientos ❒ Válvulas/uniones artificiales

❒ Sinusitis/alergias cronica ❒ Respirar por la boca

❒ Otras Condiciones _____

❒ Alergias _____

Medicaciones corrientes _____

Problemas dentales _____

Fecha de última visita dental _____ Dentista corriente _____

Información de Seguros Dental

• Seguro Dental

Nombre de Suscriptor _____ Suscriptor SSN _____ Suscriptor DOB _____

Nombre de Seguros _____ Teléfono de Seguros _____

Número de Grupo _____ Número de Contrato _____

Nombre Patronal _____ Dirección de Seguro _____

• Paga Privada (Ningún seguro o Medicaid/CHIP)

Consiento en pagar los honorarios llenos de una limpieza dental, examen, y fluoruro por visita. Los selladores son adicionales y usted será contactado antes de su colocación para arreglos de pago y aprobación.

Cheque/Orden de dinero ❒ **Por favor haga el chequel o el giro bancario pagadero a Sonrisas de Mañana y grapa a esta forma.**

Tarjeta de crédito ❒

CC Tipo _____ CC# _____ 3 dígitos de seguridad (en parte posterior) _____ Fecha de caducidad _____

Nombre como aparece en la tarjeta _____

Los precios van desde $ 121 a 220 dependiendo de la edad , paciente nuevo / regresar , y necesitan de radiografías. Por favor llame o texto 903-241-0061 para una cita exacta.*

Consentimiento/Firma Paternal REQUERIDO

Yo soy un guarda paternal o legal custodial del niño menor puesto en la lista encima. Entiendo que soy bienvenido a asitir al tratamiento del niño. Si no, autorizo a un funcionario escolar adulto para acompañar al niño durante visita dental. El adulto autorizado puede ser una enfermera escolar, el empleado principal, administrativo, o un adulto llamado por uno de ellos. Reconozco que pueden ponérse en contacto en la dirección o número de teléfono que proporcioné en cuanto al cuidado dental de mi niño.

Cuando el guarda paternal o legal custodial del niño nombró anteriormente, autorizo a Brian Dolive, D.D.S. y su personal para proporcionar el cuidado dental que puede incluir limpiezas, proyecciones, fluoruro, exámenes, selladores, y rayos X. Entiendo que el cuidado dental será proporcionado en la escuela sin mi presencia. Ninguna notificación adicional o consentimiento serán proporcionados para la provisión de limpiezas dentales, proyecciones, fluoruro, exámenes, selladores, y rayos X a menos que yo oportuno retire este consentimiento. Este consentimiento firmado autoriza la visita inicial, visitas de 6 mes, y la liberación de la información de salud más reciente de mi niño como está previsto a la escuela. Si es determinado sobre el examen del niño, la necesidad de rellenos, coronas, pulpotomies, extracciones, u otros procedimientos, el niño recibirá una remisión escrita para el tratamiento adicional, excepto en caso de una urgencia médica.

Autorizo a Brian Dolive, D.D.S. para facturar y coleccionar el pago de cualquier Seguro de enfermedad, seguro, u otro tercero pagador que cubre los servicios proporcionados a este paciente, que será aplicado a los beneficios del paciente. Si tengo el seguro privado, yo seré facturado para y consentir en pagar cualquier deductibles y/o co-pagas. También reconozco la recepción de un aviso de prácticas de intimidad atadas a esta forma de consentimiento. (Por favor guarde la forma de intimidad HIPAA para su récord).

Firmando abajo, legalmente reconozco la aceptación de estos términos y condiciones.

Firma de Guarda Paternal/legal Custodial _____ Fecha _____

Si su niño tiene a un dentista existente, usted puede desear seguir servicios dentales con aquel abastecedor. Para evitar el servicio dental o la copia de ventaja, por favor informe a su dentista qué servicios fueron proporcionados en la escuela refiriéndose a la libreta de calificaciones de salud oral que será enviada a casa con su niño después de la visita dental escolar.

Brian Dolive, D.D.S., Smiles of Tomorrow, L.L.C., 4 Huntington Circle, Longview, TX 75601, 903-241-0061.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTHY INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

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. This Notice takes effect 04/14/13, and will remain in effect until we replace it.

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 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 or other healthcare provider providing treatment for 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 healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. 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: 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 to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use and disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our healthcare. 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 and disclose your health information when we are required to do so by law.

Abuse or Neglect: We may use and 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 officers health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 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 have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, 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 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. Contact

Officers: HIPAA Officer

Telephone: 903-241-0061 Fax: 903-753-0642

E-mail: sherylhandlin@hotmail.com

Address: 4 Huntington Circle, Longview, Texas 75601