Big Smiles

THE DENTIST IS COMING TO YOUR SCHOOL!

Our school has joined with Big Smiles to offer in-school dental care at NO COST* to you.

SAVE TIME!
Sign up online
www.MySchoolDentist.com

Taking care of your child's teeth is important to keep them healthy.

EASY & CONVENIENT - A state licensed dentist will regularly check your child's mouth & teeth, as well as provide a cleaning, x-rays as necessary, fluoride treatment and apply sealants, as needed. Additional care, such as fillings, may also be provided. A dental report card will be sent home with your child. Includes initial dental care & follow-up visits. **SIGN AND RETURN TO YOUR SCHOOL TODAY!**

PLEASE COMPLETE

Child's Legal Name		Birth Date	☐ Male ☐ Female
Address	City	State	Zip
School	Teacher		Grade
Parent/Guardian Name		Phone ( )	
Email		Alt Phone ( )	

IMPORTANT HEALTH QUESTION

Does your child have any past or present medical or dental conditions, disabilities or social/behavioral issues? This may include heart issues, breathing problems, brain/seizure disorders, allergies (including drug allergies), diabetes, bleeding problems, communicable diseases or immune disorders etc. If Yes, explain below (attach additional pages as needed). IF NO, LEAVE BLANK.

List current medications _____ **List any dental concerns** _____

FOLD FOLD

IF CHILD HAS MEDICAID/KCHIP

Circle one of the following: KY Medicaid, Humana-Caresource, Aetna Better Health, Wellcare, Passport, Anthem BCBS

Enter Child's 10-digit ID Number HERE: → ☐☐☐☐☐☐☐☐☐☐

***Medicaid & KCHIP cover 100% of treatment**

OR Child's Social Security # (if available) ☐☐☐ - ☐☐ - ☐☐☐☐

IF CHILD HAS PRIVATE DENTAL INSURANCE

Ins. Company name (other than Medicaid) _____ Ins. Phone _____

Group # _____ Employer name _____ Co. phone _____

Name of Insured Adult _____ **BIRTH DATE of Insured Adult** _____

Member ID/Policy # _____ Social Security # of insured adult _____

IF CHILD HAS NO DENTAL INSURANCE

(ALSO CHECK ONE BELOW) If paying for services, staple check or money order to this form & make payable to: Big Smiles Kentucky.

☐ I will pay the reduced fee for a dental cleaning, screening & fluoride per visit. Ages 13 or younger: **$83.00** Ages 14 or older: **$90.00**

☐ I request donated care to cover the cost of a dental cleaning, screening and fluoride for my child. (We will send you a donated care application. Available only once per school year for preventive care only.)

If your child sees a dentist regularly, and you want to continue care with that dentist, you should do so.

READ & SIGN BELOW

I request that the dentist perform a dental check-up on my child at school which includes exam, cleaning, fluoride, sealants and x-rays as needed, as well as other dental work as needed, including fillings, extractions of infected baby teeth, numbing the mouth and teeth and other procedures as described more fully on the back of this page. This permission includes future dental visits. I have read the IMPORTANT HEALTH QUESTION above and will report any significant changes in my child's health to 855-481-8639. I have also read the IMPORTANT NOTICE AND CONSENT ON THE BACK OF THIS PAGE and understand and agree to its terms.

SIGN & DATE HERE _____ _____ **DATE**

For your privacy, please fold & secure.

QUESTIONS:1-855-481-8639 FAX: 1-888-330-4331 Visit us at: BigSmilesDental.com

ESPAÑOL AL REVERSO

Big Smiles Kentucky PSC
2333 Alexandria Drive, Lexington, KY 40504

Big Smiles

¡EL DENTISTA VENDRÁ A SU ESCUELA!

Nuestra escuela se unió con Big Smiles cuidado dental en la escuela SIN COSTO* para usted.

¡AHORRE TIEMPO!
Regístrese en línea
www.MySchoolDentist.com

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

FÁCIL Y CONVENIENTE - Dentistas licenciados en el estado periódicamente revisará la boca y dientes de su hijo, igual proporcionará una limpieza y tratamiento de fluoruro. También proporcionará sellantes y rayos-x tal sean necesarios. Tratamiento adicional como rellenos podrían ser propocionados. El reporte incluye el tratamiento recibido y tratamiento requerido. **¡FIRME Y REGRESE A LA ESCUELA HOY!**

LLENE POR FAVOR

Nombre Legal del Niño(a)	Fecha de Nacimiento	☐ Hombre ☐ Mujer

Dirección	Ciudad	Estado	Código Postal
Escuela	Maestro		Grado
Padre/Tutor Legal	Teléfono ( )		
Correo electrónico	Teléfono Alt. ( )		

PREGUNTA DE SALUD IMPORTANTE

¿Su hijo tiene alguna discapacidad o condiciones médicas o dentales en el pasado o presente o alguna incapacidad social / problemas de comportamiento? Puede incluir problemas del corazón, problemas de respiración, trastorno del cerebro/convulsiones, alergias (incluye alergia a medicamentos), diabetes, problemas de sangrado, enfermedades transmisibles o desorden inmunitario, etc. Si es así, por favor explique abajo (adjunte hojas adicionales si es necesario). Si No, deje el espacio abajo en blanco.

Anote los medicamentos que este tomando_____ **Anote cualquier problemas dental** _____

DOBLE DOBLE

NIÑO(A) TIENE MEDICAID/KCHIP

Circule uno de los siguientes: KY Medicaid, Humana-Caresource, Aetna Better Health, Wellcare, Passport, Anthem BCBS

Escriba los 10-digitos # de identificación del niño(a) AQUÍ: → ☐☐☐☐☐☐☐☐☐☐

***Medicaid y KCHIP cubren 100% del tratamiento**

O Número de seguro social del niño(a) (si está disponible) ☐☐☐ – ☐☐ – ☐☐☐☐

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_____

NIÑO(A) NO TIENE SEGURO DENTAL

(POR FAVOR MARQUE UNA OPCIÓN ABAJO) En caso de pagar por los servicios, engrape el cheque o giro postal en esta forma, y haga el pago a: Big Smiles Kentucky.

☐ Voy a pagar la tarifa reducida para una limpieza dental, examen y fluoruro por visita. Edad 13 o menor: **$83.00** Edad 14 o mayor: **$90.00**

☐ Certifico que no puedo pagar por el costo reducido y pido asistencia financiera completa la cual cubrirá la limpieza, examen y fluoruro. (Le enviaremos una aplicación por correo. Disponible para tratamiento preventivo solo una vez por año escolar.)

Si su hijo(a) ya tiene una dentista y gustaría seguir tratamiento con él, debería continuar con su mismo dentista.

LEA Y FIRME ABAJO

Solicito que el dentista realice una revisión dental a mi hijo(a) en la escuela la cual cubrirá el examen dental, limpieza, fluoruro, sellantes, y rayos-x como sean necesarios, así como otros trabajos dentales según la necesidad, incluyendo rellenos, extracciones de dientes de leche infectados, adormecimiento de la boca y dientes y otros procedimientos como se describe con más detalles en la parte posterior de esta página. Este permiso incluye visitas al dentista en el futuro. He leído la PREGUNTA IMPORTANTE DE SALUD al anterior y les informaré de cualquier cambio significante del salud de mi hijo(a) a 855-481-8639. He leído la ADVERTENCIA IMPORTANTE Y CONSENTIMIENTO EN LA PARTE POSTERIOR DE ESTA PAGINA, entiendo y estoy de acuerdo con sus términos.

FIRME Y FECHA AQUÍ _____ _____
FECHA

Para su privacidad doble y asegure.

PREGUNTAS:1-855-481-8639 FAX: 1-888-330-4331 Visítenos en: BigSmilesDental.com

Big Smiles Kentucky PSC
2333 Alexandria Drive, Lexington, KY 40504

IMPORTANT NOTICE & CONSENT / AVISO IMPORTANTE Y CONSENTIMIENTO

I understand and authorize Big Smiles Kentucky PSC (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 & oral hygiene instruction, teeth cleaning, fluoride treatment, x-rays & dental sealants. I authorize the dentist to fill any cavities or to place a crown over the tooth if needed. I authorize Provider to extract any problem baby teeth or perform a pulpotomy (treatment of the nerves inside the tooth) as needed. I understand that there are risks to dental treatment including swelling or pain that may occur from the injection of a local anesthetic or allergic reaction. (For additional information regarding the risks of treatment and treatment alternatives, please call the number provided.) I authorize & direct Provider to bill & collect payment from any Medicaid, insurance, or other payer. 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 Big Smiles Kentucky PSC (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. Autorizo al dentista a que atienda cualquier carie o coloque una corona sobre el diente si es necesario. Autorizo al Proveedor a extraer cualquier diente de leche con problema o realizar una endodoncia (tratamiento de los nervios dentro del diente), como sea necesario. Entiendo que existen riesgos al recibir tratamientos dentales incluyendo inflamación o dolor que puede ocurrir de la inyección de la anestesia o una reacción alérgica. (Para información adicional sobre los riesgos del tratamiento dental y tratamientos alternos 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 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

BIG SMILES KENTUCKY PSC • PRACTICE OWNERSHIP DENTIST: DR. ELLIOT SCHLANG, DDS

James Rolin, DMD, Gina Davis, DMD, Shana Dean, DMD, Kathleen Donley, DDS, Jeffrey Edwards, DMD, Candace Flener, DMD, Alan Jones, DMD, Louis Leslie, DMD, George Ochs, DMD, Matthew Pelais, DDS
Ronald Singer, DDS, Adam Stowe, DMD, Christina Stowe, DMD, Ashley Tynan, DMD, Gayatri Varanasi, DMD, Lauren Weber, 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 888-833-8441.

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 concerned 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.

Phone: 888-833-8441

Fax: 888-330-4331

email: hipaaofficer@smileprograms.com

Effective Date: August 1, 2016