SMILES ACROSS MONTANA, LLC
PREVENTATIVE DENTAL CARE

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Dear Parents/Guardians:

Smiles Across Montana (SAM) is a dental hygiene program that focuses on dental disease prevention. Our services are provided at your child's school and there is no fee to the child or family for our services. We do bill Medicaid/HMK/HMK+/Private Dental Insurance. Our goal is to see students 3 times a year. Your child will be seen by a dental hygienist working under the direct/general supervision of a dentist and will receive one or more of the following preventative services:

- Cleanings: Removes all hard and soft material that forms on the teeth. SAM staff will also offer the student education on how to properly care for their teeth at home and make good food choices for their healthy future.
- Sealants: A thin plastic coating that fills in the deep grooves on the chewing part of the tooth. They are easy, painless and will help prevent decay as your child grows.
- Fluoride Varnish Treatments: A protective coating that is painted on the teeth to help strengthen the tooth structure helping the teeth to be more resistant to decay.
- Silver Diamine Fluoride Treatments: Aids in stopping decay as well as preventing future decay on the tooth.
- Oral Health Instructions
- Referrals to a Dental Home or Dentist of Record
- Exam, by a dentist, and x-rays-at select locations

WHY IS DENTAL PREVENTION IMPORTANT?

- What is decay?
  - Decay is a cavity in either the baby tooth or the adult tooth that is caused by many different factors (diet, genetics, oral hygiene, etc.)
  - Decay in children's teeth can be prevented.
  - Decay can be painful and in some cases can cause more irreversible problems. This pain can also cause a child to miss school.

HOW CAN THIS EFFECT YOUR FAMILY, HOW CAN WE HELP?

- Many families cannot take time off of work to take their children to regular preventative dental appointments, or some families do not have a dental home.
- Assist families in enrolling child into Medicaid so they may be covered for any treatment that might be recommended.
- All children will be seen no matter their ability to pay or access to dental insurance.
- We will provide families with a note regarding what services were provided and any recommended referrals. Any urgent concerns, the hygienist will notify family ASAP with referrals.
- Provide the facility a list of referring Medicaid offices accepting new pediatric patients in case of dental emergency, if needed.
- It allows all children to be seen regularly without the parent having to take time off work for preventative treatment or the child missing school.
- We want to work with the dentist of record so that the children receive the total care they need, but if the family has no dental home, we will work to ensure that the family is given multiple options on where they can receive treatment.

Please return the last two pages to your child's teacher/administrator. You may keep the first two pages for your own records.

HIPAA Privacy Rule http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/notice.html

Notice of Privacy 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.

With your consent, the program is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of use of your health information for treatment purposes: Clinical staff obtains information about you and records it in a health record. During the course of your treatment, the clinical staff determines a need to consult with another dental professional in the area. The clinical staff will share the information with dental professional to obtain input.

Example of use of your health information for payment purposes: The program may submit a request for payment to Medicaid/CHIP and/or your insurance company. Medicaid/CHIP or the insurance company may request information from us regarding the dental care provided. We will provide information to them about you and the care given.

Example of use of your information for health care operations: The program tracks internal information regarding the populations served by the program through detailed measurements to include but are not limited by: quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, insurance filings and outreach assessments. We will share information about you with our partners as necessary to obtain services, program review and funding opportunities.

The health records we maintain and billing records are the physical property of the program. The information in it, however, belongs to you. You have a right to:

· €Request a restriction on certain uses and disclosures of your health information by delivering the request in writing tour office. We are not required to grant but we will comply with any request granted;

· €Request that you be allowed to inspect and copy your health record and billing record-you may exercise this right by delivering the request in writing to the program;

· €Appeal a denial of access to your protected health information except in certain circumstances;

· €Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to the program;

· €File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;

· €Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to the program. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to family members or friends in the course of providing care;

· €Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,

· €Revoke authorization that you made to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to the program.

Our Responsibilities

The program is required to:

· Maintain the privacy of your health information as required by law;

· Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;

· Abide by the terms of this Notice;

· Notify you if we cannot accommodate a requested restriction or request; and

· Accommodate your reasonable requests regarding methods to communicate health information with you.

The program reserves the rights to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information changes, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our “Notice”.

To request information or file a complaint

If you have questions, and would like additional information, or want to report a problem regarding the handling of your information please write to:

Smiles Across Montana
37 Jefferson Dr.
Clancy, MT 59634

You may also file a complaint by mailing it or emailing it to the Secretary of Health and Human Services.

· The program cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment. Nor will the program retaliate against you for filing a complaint.

Other Disclosures

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, social worker, school counselor, schoolteacher, or other person responsible for your care, about your location, and your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, or other person responsible for your care, your health information relevant to that person’s involvement in your care or in payment for such care if you do not object or in an emergency.

Abuse and Neglect

The program may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Smiles Across Montana (SAM) is a preventive oral health program provided by a registered dental hygienist who is under direct/general supervision of a dentist. All students are eligible to receive care. All restorative dental needs will be referred to your current dental home or partnering community dental office/clinic. This consent is valid until the child is no longer a student.

YES, I authorize a registered dental hygienist to perform preventative dental services, to include dental cleaning (prophylaxis), fluoride varnish, dental screenings/assessments, referrals, placement of dental sealants and placement of silver diamine fluoride as needed, and in some cases, x-rays. I also agree to a licensed Dentist to provide exams at select locations either live or by tele-exam. I agree not to hold SAM or its partners liable for any negative reactions as a result of care received for my child. If applicable I approve the billing of Medicaid/HMK/HMK+/Private Dental Insurance for services provided. I understand no information will be shared to any person not directly involved in the care of my child. I allow the use of my child's image for SAM. I have had an opportunity to review SAM's Privacy Practices and the attached HIPAA document.

Parent or Guardian: _____ **Parent or Guardian:** _____**Date:** _____
SIGNATURE (MUST HAVE THIS!!) **PLEASE PRINT NAME**

Name of child: _____ Male: _____ Female: _____ Date of Birth: _____

Home Address: _____ City: _____ Zip: _____

Parent Phone: _____ Cell Phone: _____ Texting:_____ YES _____ NO

Email: _____

School: _____ Teacher: _____ Room: _____ Grade: _____

Medical/Dental History:

1. About how long has it been since your child last visited a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists. **(Please check one)**
6 months - 1 year ago _____ Over 1 year _____ Never has been to the dentist _____

2. Has your child gone to the dentist for routine care _____ **OR** emergency care _____? **(Please check one)**

3. Is your child experiencing oral pain (toothache, sore gums, etc.)? YES_____ NO _____

5. Does your child have an established dentist? YES _____ NO _____ If yes, name of dentist_____

7. Has your child ever had a serious health problem?_____

8. Did you take your child to a hospital emergency room for a dental-related emergency this year? YES _____ NO _____

9. Is there anything we should know about your child prior to treatment?_____

10. Is your child on any medications, if **YES** list? _____

11. Does your child have any allergies (e.g., medicine, latex, nuts, etc.)?_____

Dental Insurance Information (note: your family will not receive a bill for services not covered by your insurance, this is to maintain our program and keep it sustained. Any services through SAM billed to your insurance may limit coverage with any other dental provider you seek care with. It is extremely important that you inform any other provider, BEFORE scheduling, that services were provided by SAM to prevent unexpected out of pocket expenses.)

Medicaid/HMK/HMK +? Y_____ N_____ Medicaid Insurance #:_____
Private Dental Insurance Company/Plan Name _____
Address, City, State, Zip: _____
Policy Holder/Subscriber Name (First, Middle, Last)_____
Address, City, State, Zip:_____
Date of Birth:_____ Gender (M) (F) Policyholder/Subscriber ID (SSN or ID#) _____
Plan/Group Number _____ Patient's relationship to policyholder_____
Employer Name: _____

Family Survey:
This is *CONFIDENTIAL* information and will only be used to serve the needs of the community.

1) Total number in the household (incl. yourself):
    a. 2-4
    b. 5-6
    c. over 6

2) Monthly Income:
    a. $0-500
    b. $501-1,000
    c. $1001-2,000
    d. $2,000+

3) What highest school grade did you complete?
    a. Some high school
    b. HS Diploma
    c. Some college
    d. Associates degree
    e. Bachelor's degree
    f. Beyond a bachelors

4) Does your child participate in free/reduced lunch? YES
NO

5) What is your source of income?
    a. No income
    b. Government Assistance
    c. Employment
    d. Other

6) What is your current housing?
    a. Own
    b. Rent
    c. Homeless
    d. Other

7) How would you rate your oral health status?
    a. Great
    b. Good
    c. Needs improvement
    d. Poor

8) Does your family have access to dental care? If no, why (ie. no transportation, not Medicaid eligible, etc)?
    a. Yes
    b. No _____

9) If participating in this program, what is the main reason why?
    a. Convenience
    b. Difficulty finding a dentist to take your insurance
    c. Cannot take time off of work for appointments
    d. No dental insurance
    e. other _____