Ronald McDonald Care Mobile

In Partnership with The Health Center

157 Towne Ave, Plainfield VT 05667

Phone: 802-322-6622 Fax: 802-322-6602

Mobile Dental Van

The mobile dental van, sponsored by Ronald McDonald House Charities in partnership with the Community Health Centers of Vermont is a modern, fully equipped dental office on wheels. The Health Center in Plainfield, Vermont provides the management, staff and financial support to bring the van to local schools. Services from our licensed dentists, hygienists and assistants include cleaning teeth, exams, fillings, x-rays, extractions, and sealants.

Does your child have a dentist? If not, getting dental care at school is possible!

What steps do you have to take to enroll your child?

- Complete an application (enclosed in this packet). Your school nurse will be happy to help you fill it out if you need a hand.
- Find out if your child is eligible for Medicaid- dental services are covered completely with this type of insurance and we take care of all billing.
- If you have private insurance, we will bill the insurance company and you will be responsible for paying any balance.
- We do offer a “sliding scale” for families who don’t qualify for Medicaid, don’t have insurance or have private insurance but may be considered low income. This is funded by Ronald McDonald House Charities and The Health Center and reduces what you owe. There is a financial assistance application to fill out- your school nurse or principal or anyone on the dental van can get this to you. This is all handled and processed at The Health Center.

The evidence is strong that good dental care results in fewer missed days from school, a better chance of success in school and work and prevents many diseases including diabetes. Partnering with schools makes going to the dentist easy! The school nurse is key to getting applications filled out and health insurance information provided so we have all the paperwork to move forward. We have an administrative assistant who can help you fill out Medicaid application if needed, answer any questions and sets up all appointments.

Fill out the application and get it back to school as soon as possible. The mobile dental van will be in your area soon and the schedule is filling up quickly. Hope to see your bright smiles soon☺

Any questions, please call: Stasi Ford@ 802-322-6622 or by email at dentalmobile@the-health-center.org

Mobile Dental Van

Operated by: The Health Center
157 Towne Avenue PO Box 320
Plainfield, Vermont 05667

Application

Please fill out this form as completely as possible so we can provide the best possible dental care for your child. The information in this application will be held in strict confidence. Please circle YES or NO where indicated. If you need assistance in completing this form, please contact the school nurse or call or email Stasi, the van assistant at 802-322-6622 or at dentalmobile@the-health-center.org

MEDICAL/DENTAL HISTORY

Name of Child_____ **Date of Birth** ___/___/___
Does your child have a Doctor? YES NO
Child's Primary Care Doctor:_____**Phone:**_____
Pharmacy_____ **Weight:**_____

Does your child have a Dentist? YES NO
Dental History: if yes: Dentist Name_____ **Date of Last visit**_____
Have there been any injuries to your child's teeth, mouth or head in the last year? □ Yes □ No
Has your child had any unpleasant experiences in dental or medical office? □ Yes □ No
Do you have any special concerns about your child's teeth, gums or mouth? □ Yes □ No
If yes to any of above, describe:_____
How many times are your child's teeth brushed per day? _____
Please describe your child's temperament:
Friendly Talkative Shy Nervous Active Aggressive Unmanageable

Medical History:
Is your child taking any prescription and/or over the counter medications?
If yes, please list_____
Does your child have any allergies?
If yes, please list_____
Has your child ever been hospitalized? □ Yes □ No
If yes, when_____ reason_____
Any medical conditions or concerns not listed? _____
Does your child have a history or ever been diagnosed with any of the following?

- □ Anemia
- □ Arthritis/Rheumatism
- □ Allergies
- □ Artificial Heart Valve
- □ Artificial Joints
- □ Asthma
- □ ADD
- □ Autism
- □ Birth Defects
- □ Brain Injury
- □ Brain Surgery
- □ Cancer
- □ Chemotherapy
- □ Cerebral Palsy
- □ Cleft lip/palate
- □ Diabetes
- □ Eye Problems
- □ Kidney Problems
- □ Tuberculosis
- □ Hearing loss/aids
- □ Heart problem/surgery
- □ Heart Murmur
- □ Hemophilia/bleeding disorder
- □ Hepatitis, type_____
- □ High/low blood pressure
- □ HIV/AIDS
- □ Fainting
- □ Rheumatic Fever
- □ Behavior/Learning Disability

PARENT/GUARDIAN SIGNATURE:_____**Date:**_____

CHILD NAME: _____ DATE OF BIRTH:_____

SS#:_____ SEX: M or F SCHOOL NAME _____

GRADE_____MAILING ADDRESS: _____

CITY:_____ STATE:____VT_____ZIP:_____

EMAIL: _____ OK to send email message ___yes ___no

PHONE (H)_____ PHONE (M)_____PHONE (W)_____

If unable to reach you, may we leave a message on your answering machine? YES NO

(IF PATIENT IS A MINOR) LIVES WITH: mother _____father _____both _____ other_____

Mother's name _____Father's name_____

LEGAL GUARDIAN:_____ PHONE #:_____

Person to notify in case of emergency, if we are unable to reach parent/legal guardian:

Name:_____Relationship_____
Phone:Home_____Cell:_____Work:_____

DENTAL INSURANCE INFORMATION: Please supply a copy of both sides of your insurance card(s).

NAME OF INS:_____ CERTIFICATE#:_____

GROUP #:_____ SUBSCRIBER NAME:_____

SUBSCRIBER DOB:_____ SS#_____

DO YOU HAVE MEDICAID/DR DYNASAUR? YES NO MEDICAID #_____

As a Federally Qualified Health Center, we are required to ask these questions. The information will be kept confidential and will not impact your care.							
Plese circle your race:	Caucasian (white)	Alaska Native or American Indian	Black/ African American	Asian	Native Hawaiian	Other Pacific Islander	Refuse to Report
Are you of Latino/Hispanic Ethnicity? Yes No							
Are you Homeless? Yes No							
Please circle how many people live in your home: 1 2 3 4 5 6 7 8 If larger: #_____							
What is the combined annual income of all people living in your home? $_____							

ACKNOWLEDGEMENTS:

I acknowledge that I previously have received from THC:

1) Patient's Bill of Rights/Contract of Care
2) HIPAA Notice of Private Practice
3) Credit and Collection Policy Initial_____

Parent/Guardian Signature: _____ Date: _____

********** Consent to Treat a Minor **********

On behalf of my minor child, _____, I authorize the dental staff of **The Health Center** to perform dental procedures for my child on the Ronald McDonald Care Mobile.

If there are any procedures you do not wish to be performed, please cross off and initial.

Hygiene/Preventive Treatment:

- X-Rays, as needed (X-Rays are necessary to diagnose decay and are routinely done based on risk assessment)
- Cleaning
- Sealants (applied to deep grooves on permanent teeth)
- Fluoride Treatment

Dentist

- Routine fillings – Composite Resin (white filling)
- Local anesthetics as needed (numbing)
- Pulpotomy (indicated for baby teeth with deep decay)
- Stainless Steel Crown (Silver Cap)
- Extractions (We will attempt to notify the parent/guardian prior to tooth extraction. In the event the parent/guardian is not reached and there is infection, trauma, or pain, the extraction will be performed)
- Silver Diamine Fluoride (SDF- medicament applied to teeth to help stop the progression of decay. It might require re-application and/or a definitive treatment. It will turn the decay black and can temporarily discolor surrounding gums)

Photography:

- Photography (Only check if you DO NOT want us to take photo's)
    - I grant permission for The Ronald McDonald Care Mobile (RMCM) to take and use photographs of my child/ward in publications, news releases, and in other communications related to the mission of RMCM.

- In the event that emergency treatment is required; parent/guardian will be contacted as soon as reasonably possible.
- I understand that this consent form is valid for as long as my minor child is receiving dental care on the Ronald McDonald Care Mobile.
- I understand that the dentist or dental hygienist will provide a written report of any work completed at the visit, with instructions as needed.
- We will continue to see your child unless told otherwise by a parent/guardian.

Parent/Guardian Signature: _____ Date: _____

As a patient, you have both rights and responsibilities when it comes to your dental health and the dental services you receive on the RMCH Dental Van.

********** Your Rights **********

You are entitled to:

- Expect that you will be treated fairly and respectfully without regard to your age, race, religion, income, etc.
- Have reasonable access to care.
- Expect that your requests will be considered.
- Know the name and job of the people providing you with care.
- Know about your dental treatment plan
- Give your consent to treatment and care, except in cases of emergency.
- Refuse treatment you do not want.
- Have family members involved in your care and decisions to the extent you choose.
- Have your privacy respected.
- Know what is in your dental record.
- Receive a bill you can understand or have that bill explained to you.
- Know The Health Center rules as they apply to your conduct as a patient.
- Have an interpreter if you need one.
- File a written or verbal complaint if you are unhappy with your care.

********** Your Responsibilities **********

You are expected to:

- Keep appointments or cancel/reschedule with at least 24 hours notice.
- Be considerate of other patients and their privacy.
- Observe safety regulations including non-smoking rules.
- Supply full and accurate personal and health information as requested.
- Recognize the effect of your lifestyle on your personal health.
- Work with the dental team to make informed health decisions.
- Let us know if you do not understand or cannot follow directions.
- Be aware of what your health care insurance does and does not cover.
- Know what medications and over-the-counter drugs you are taking.

BEFORE SIGNING, BE AWARE OF YOUR RIGHTS AND WHAT YOUR SIGNATURE MEANS

I certify that I represent my son/daughter to obtain dental services provided by The Health Center on the RMCM dental van. I give permission to release information to obtain payment from my insurance company. I understand that information will be shared with my child's school. I have received and read the notice of privacy practices, patient rights and responsibilities and attest that all the information in the application provided is accurate and complete to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES – Effective Date: 9/23/13

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. These privacy practices are followed by the employees, staff and other personnel of The Health Center. Please review it carefully. If you have any questions about this notice, please contact The HIPAA Privacy Officer or Compliance Officer at The Health Center 802-454-8336.

OUR OBLIGATIONS:

We are required by law to:
Maintain the privacy of protected health information
Give you this notice of our legal duties and privacy practices regarding health information about you
Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the health care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or/ disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Psychotherapy health information. Psychotherapy information, if applicable, will not be shared without your express permission.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

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. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

(The Health Center does not intend to use your Protected Health Information for either of these purposes.)

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to The Health Center. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the HIPAA Privacy Officer at The Health Center.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to The HIPAA Privacy Officer at The Health Center.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the HIPAA Privacy Officer at The Health Center. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the HIPAA Privacy Officer at The Health Center. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, call The Health Center 802-454-8336.

Right to Opt Out of Fundraising. From time to time, The Health Center may engage in fund raising for the benefit of the Center. You may request in writing that The Health Center will not contact you with any fund raising material.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the HIPPA Privacy Officer or Compliance officer at The Health Center 802-454-8336. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit the Health and Human Services website: www.hhs.gov/ocr/privacy/hipaa/administrative/

CREDIT AND COLLECTION POLICY

The Health Center's credit and collection policy is necessary to assure the necessary financial resources are available to maintain its health care facilities for its patients and community.

- Charges for services are due and payable at the time services are rendered. Unless you have insurance to cover the cost of services provided by The Health Center, we expect payment of the full bill at the time of service unless other arrangements are worked out in advance. Everyone is expected to pay their co-pays not covered by insurance at the time of service. We initiate claims for all insurances for you; however, we do not participate in all insurances. It is your responsibility to know what your insurance covers and whether or not they participate with our practice.

- Your insurance company will notify you of their actions. It is your responsibility to keep up with what is paid or not paid and to deal with the insurance company concerning any inquiries. Insurance companies will often send letters to you requesting additional information before a claim is paid. Please make sure you respond to these in a timely manner.

- When you check out after a visit, you will be given a copy of the encounter form which records the services you received. We will not ordinarily send you another printed claim form after you are given this form, so you should retain your encounter form for your records. We expect payment of accounts within 30 days after your insurance pays or denies a claim.

- If you are unable to pay in full at the time of service, please arrange with the bookkeeper to pay as much as you can and plan to complete payment within 30 days of services.

- Once your insurance pays or denies, we consider you to have a personal balance pending. If a personal balance is not entirely paid within 60 days of service and you do not have an acceptable time payment plan, the account is handled on a cash only basis thereafter. If an account is not paid in full or satisfactory arrangements are not made after 90 days, you will receive a notice stating we will provide no further health care services to the family and your account will be sent to our attorney. All court costs and lawyer fees will be added to your account and will be your responsibility to pay.

- If unusual circumstances should make it impossible for you to make payment within 30 days, we invite you to call or personally discuss the matter with our Accounts Receivable Representative at (802) 454-8336. This will help avoid misunderstandings and enable you to keep your account in good standing.

- If you need assistance applying for insurance or feel you may qualify for our sliding scale, please ask to speak to our Community Resources Department. We wish to help you in any way we can so your medical bills do not become burdensome.