ProSmiles of Montana/Smiles Across Montana, LLC

Providing equitable preventative dental care to all Montanans!
info@smilesacrossmontana.org
smilesacrossmontana.com

Dear Parents/Guardians:

ProSmiles of Montana is a mobile dental program focusing on the prevention of oral and systemic diseases, with the support of our foundation, Smiles Across Montana (SAM). ProSmiles/SAM submits for insurance reimbursement and provides scholarships. ProSmiles/SAM delivers continuity of care by striving to see each enrolled student at least 3 times per school year. Each enrolled student will be seen by a registered dental hygienist working under the direct/ general supervision of a dentist and will receive one or more of the following preventative services:

- Prophylaxis (cleanings): Removal of hard and soft materials that form on the teeth.
- 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 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. https://www.elevateoralcare.com/site/images/AASDF%20Image%20Sheet_092619.pdf
- Oral Health Instructions (including tooth brushing demonstration) and Nutritional Guidance
- Referral to a Dental Home or Dentist of Record
- Exam, by a dentist, and x-rays deemed necessary and prescribed by the dentist

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, arrested, or treated as needed by a dentist.
  - Decay can be painful, life altering (missed school days, inability to concentrate, and systemic complications) and in some cases can cause irreversible problems.

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

- Many families cannot take time off of work to take their children to regular preventative dental appointments and others may not have access to a dental home.
- By assisting families in the enrollment of Medicaid when applicable.
- We will provide families with a note regarding what services were provided and any recommended referral. The registered dental hygienist will notify the family following the appointment with any urgent concerns.
- Provide a list of offices accepting new Medicaid pediatric patients in case of a dental emergency, if needed.
- It allows all consented children to be seen regularly without the parent having to take time off work for preventative treatment or the child missing school.
- ProSmiles/SAM will collaborate with the dentist of record to ensure that the children receive recommended treatment. If the family has no dental home, we will work to ensure that the family is given multiple options of providers in their area.

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

IF YOUR CHILD IS SEEN AT A DENTAL OFFICE ON A REGULAR BASIS (EVERY 6 MONTHS) FOR CLEANINGS YOU MAY CHOOSE NOT TO UTILIZE SAM SERVICES, THERE IS NO NEED TO SIGN THIS CONSENT.

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:

ProSmiles of Montana
105 Grey Wolf Trail
Bozeman, MT 59718

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.

ProSmiles of Montana/SAM is a preventive oral health program with services provided by registered dental hygienists who are 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 or is opted out of the program. ProSmiles of Montana is supported by the nonprofit Smiles Across Montana (SAM) to ensure all students can receive these services.

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 x-rays when prescribed by a dentist. I also agree to a licensed Dentist to provide exams at select locations either live or by tele-exam. I agree not to hold ProSmiles/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. If I am unable to cover the cost of uninsured service, I understand there is a scholarship available to cover these costs. 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 ProSmiles/SAM. I have had an opportunity to review ProSmiles/SAM's Privacy Practices and the attached HIPAA document.

Risks related to Silver Diamine Fluoride include, but are not limited to: • When treatment works, the cavity will become hard and darken in color. Healthy tooth structure will not darken. • If accidentally applied to the skin or gums, it may **temporarily** stain but **causes no harm.**

Parent or Guardian (Printed Name): ____Date:_________________

Parent or Guardian (Signature) MUST HAVE THIS TO PROVIDE SERVICES: _______________________________________

Name of child:____Male:____ Female:____ Date of Birth: ____________

Home Address: ____________________________________City:______________________ Zip:________________

Parent Phone: ________________________ Cell Phone:______________________ Texting: YES____ NO____

Email:____ Preferred Method of Contact: Email___ Phone___ Text____

School:__________________________ Teacher:_________________ Grade:__________

Medical/Dental History:

1.Does your child have an established dentist? NO___ YES___Name of dentist: ________________________________

2. When was your child's last dental cleaning?__________________ Dental Exam?___________XRays?____________

3. Is your child experiencing oral pain (toothache, sore gums, etc.)? YES____ NO_____

4. Has your child ever had a serious health problem? No___ Yes___ Explain____

5. Did you take your child to a hospital emergency room for a dental-related emergency this year? YES___ NO___

6. Is there anything we should know about your child prior to treatment? ____

7. Is your child on any medications, if **YES** list?____

8. Does your child have any allergies (e.g., medicine, latex, nuts, silver, etc.)?____

Dental Insurance Information To remain compliant SAM is required to bill for services provided and not covered by insurance.SAM is committed to eliminating oral health disparities and has developed a scholarship program to cover any unpaid costs associated with your appt in our clinic. You may opt into the scholarship program below. **Any services provided by ProSmiles of Montana/SAM and submitted to your insurance may limit coverage of the insured if seeing a provider for the same services. It is extremely important that you inform any other provider, BEFORE scheduling, that services were provided by SAM to prevent duplication of services and out-of-pocket expenses.) PLEASE FILL OUT COMPLETELY IF APPLICABLE

- Medicaid/HMK/HMK +? Y____ N_____ Medicaid Insurance #: ____
- Private Dental Insurance Company/Plan Name Attach photocopy of card is possible___________________________

  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: __________________
- Opt in to Smiles Across Montana Scholarship Program: Yes_____ No ______