HELLO PARENTS!

Our programs satisfies State mandated dental exams

This page is for you to keep

Smile Michigan...the mobile dentists
Is Coming Soon!

Register your child now for both initial and 6-month dental check-ups and restorative care, if available

Fill out the permission slip today!

Our program is a highly acclaimed on-site dental care program created in compliance with the Center for Disease Control (CDC) and the U.S. Surgeon General guidelines

Our Michigan dentists can provide these **Preventive and Restorative** services:

- Dental exams/screenings
- Cleanings
- Fluoride and Fluoride Varnish
- Radiographs
- Sealants (a thin, plastic material painlessly applied on the chewing surfaces of the back teeth to prevent tooth decay)
- Fillings
- Pulpotomies on baby teeth
- Simple extractions of primary teeth
- All children are eligible for the screening, cleaning and fluoride treatment
- Grant-assistance available
- X-rays shared when needed
- FREE toothbrushes
- We supply a dental "report card" that is sent home with your child after each visit.
- If further dental care is needed, referrals are available.
- Medicaid/MIChild cover 100% of our treatment. Most private dental insurance accepted.
- Grants provide dental preventive services for children needing financial assistance.

 FORM 101PR

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 04/14/03, 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 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 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 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 or 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 professional judgment disclosing only health information that is directly relevant to the person's involvement in your 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 or disclose your health information when we are required to do so by law.

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 to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials 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 or 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.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it 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.

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 Officer: HIPAA Officer

Telephone: 1-888-833-8441 Fax: 1-888-330-4331

E-mail: caringdental@mobiledentists.com

Address: 33533 W. Twelve Mile Road, Farmington Hills, MI 48331

Tear off here – This page is for you

Smile Michigan...the mobile dentists

Please return this form to your child's teacher in the next 2 days

☺ **Signature required.** Signed consent includes **initial visit** and **6-month check-ups** when appropriate. Optional restorative visit, if available.
☺ Preventive treatment may include cleaning, screening and fluoride, exams, radiographs, sealants and referral when necessary.*
☺ Restorative treatment is optionally available and may include, but is not limited to, fillings, pulpotomies and simple extractions.

General and Health Information

School or Program Name: _____ County: _____

Teacher: _____ /Grade: _____ /Child attends: M T W TH F (circle) AM PM

Child's Legal Name: _____ (First) _____ (Middle) _____ (Last)

Child's Date of Birth: _____ (Month) (Day) (Year) Child's Sex: M F (Circle one) Last Dental Visit: _____

Your child's Social Security number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Parent/Guardian Name: _____ (signing below) Cell or Phone: ( ) _____ (area code)

Address: _____ City/Zip: _____

Relationship to child: _____ E-MAIL: _____

Has your child had any history of, or conditions related to, any of the following: Explain below. ☐ **NONE**

Asthma	Y	N	Latex allergy	Y	N	Heart murmur (not requiring pre-medication)	Y	N	Allergies - What?	Y	N
Hemophilia	Y	N	Diabetes	Y	N	Heart murmur (requiring pre-medication)	Y	N	_____		
Blood disorder	Y	N	Hepatitis	Y	N	HIV/AIDS	Y	N	Other	Y	N
Dental problems - explain below	Y	N	Heart Valve Replacement	Y	N	Shunts or artificial joints	Y	N	_____		

✱ **IMPORTANT:** List all medications, health history, medical and dental conditions below. *Attach another page if more space is needed.* **PLEASE INFORM US AT THE 6-MONTH VISIT IF THERE IS ANY CHANGE IN MEDICAL & DENTAL CONDITION BY FILLING OUT A NEW PERMISSION FORM.**

Medicaid/MIChild

☺ We accept *Medicaid, MIChild* and most private insurance.

Child's **10**-digit Medicaid Recipient ID Number: ☐☐☐☐☐☐☐☐☐☐

Name of Private Dental Insurance Company (other than Medicaid): _____ Ins. Phone: _____

Group number: _____ Employer name: _____ Co. Phone: _____

Name of person under whom child is covered: _____ **BIRTH DATE of Insured Adult:** _____

Social Security number of insured adult: _____ Contract / ID number: _____

Secondary insurance information: Insurance Name: _____ Policy Holder: _____ Date of Birth: _____

ID Number: _____ Employer Phone: _____ Insurance Co. Phone #: _____

No Medicaid or Dental Insurance — Only Check ONE Box

☐ I am able to pay the full fee for a dental cleaning, screening & fluoride per visit.
Ages 13 or younger: **$80.00** Ages 14 or older: **$104.00**
Please make check or money order payable to **Smile Michigan P.C.** & staple to this form.

☐ I need to pay for a subsidized service because I am unable to pay full fee.
It will cover dental cleaning, screening & fluoride.
Ages 13 or younger: **$39.00** Ages 14 or older: **$60.00**
Please make check or money order payable to **Smile Michigan P.C.** & staple to this form.

☐ Check here if you need financial aid for insurance co-pays/ deductibles if any. Most insurance covers prevention 100%.

☐ Check here if you have NO dental insurance **AND** you need full financial assistance for cleaning, screening & fluoride (grants unavailable for restorative care). We will mail you a grant application. Grants are available only once per year.

IMPORTANT: Parent/Guardian Signature Required

(1) *As custodial parent or legal guardian of the minor child named above, I authorize and consent to this (my) child receiving from Smile Michigan P.C. and its affiliated dentists the preventive dental treatment described above, and allow the school nurse/school representatives, the local public health department(s), and/or a dentist of my choosing to obtain the child's dental record and radiographs. I authorize and direct Smile Michigan P.C. to bill on my behalf or the child's behalf; and collect payment from any insurance or other third party payer that covers the services provided to this child. I have had an opportunity to ask any questions about treatment my child may receive. I acknowledge receiving a notice of privacy practices today before signing. I understand that this child will receive the results of the dental exam on an Oral Health Report Card given to the child on the day of treatment. If I do not receive it or need another copy I will contact the toll free number listed below.*

X **SIGN HERE** _____ Date: _____
(Parent/Guardian)

(2) **FILLING CAVITIES AND MORE** - *after the prevention visit, the dentist may indicate the need for additional treatment. In some schools, Smile Michigan P.C. will be performing the follow-up restorative care. Sign your name below if you wish to grant permission for your child to receive the necessary additional restorative care at school, if available. Smile Michigan P.C. and its affiliated dentists will deliver restorative care, which can include, but is not limited to fillings, pulpotomies, simple extractions and local anesthesia to numb for the patient's comfort, if necessary. I further authorize, Smile Michigan P.C. to bill on my behalf or the child's behalf and collect payment from any insurance or other third party payer that covers the services provided to this child. I understand that in some cases the dental treatment may not be able to be finished at school due to complexity or time restraints. If necessary, a referral will be made to the address and/or phone number of record on this application form. My signature set forth immediately below authorizes consent to all terms, conditions and acknowledgements set forth in paragraphs (1) and (2) covering both preventive and restorative dental care.*

X **SIGN HERE** _____ Date: _____
(Parent/Guardian)

If the child has a 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 performed at school (see oral health report card, provided after school dental visit, which will indicate services provided).

* *Radiographs are taken & sealants applied at dentist's discretion. In cases where additional dental care is required for restorative and/or other dental needs, the parent/guardian must follow up with a dentist of their own choosing.*

Elliot P. Schlang, D.D.S., Dental Director, Smile Michigan P.C., 33533 W. Twelve Mile Road, Ste. 150, Farmington Hills, MI 48331 **Phone:1-888-833-8441, Fax:1-888-330-4331**

Visit us at: www.mobiledentists.com

