

Jefferson County Health Department, Smiles To Go.

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.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

Dentists participating in the Jefferson County Health Department Smiles To Go program may be required by applicable federal and state law to maintain the privacy of your health information. Protection of patient privacy is important to participants in the Jefferson County Health Department Smiles To Go Program. This notice summarizes the privacy practices that will be followed by participants in the Jefferson County Health Department Smiles To Go Program, and your rights concerning your health information. This Notice will apply to health information collected in connection with the Jefferson County Health Department Smiles To Go program.

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. For example, we may use or disclose your health information to another dentist, physician or other health care provider providing treatment to you. Patient information may be released to school health service staff to assist in providing care.

Your Authorization: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. 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.

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 involved in your treatment to the extent necessary to help with your healthcare.

Persons Involved In Care: 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 authorize 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.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of the Notice for assistance in reaching the dentist or facility holding your health information.

Disclosure Accounting: You may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or certain other activities for the last 6 years, but not before April 14, 2003.

Restriction: You may 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 may request that we communicate with you about your health information by alternative means or to alternative locations. We may agree to reasonable requests.

Amendment: You may 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.

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: Robert Lapp, Privacy Officer
Telephone: (312) 440-2750 Fax: (312) 440-2924
E-mail: lappr@ada.org
Address: American Dental Association, 211 E. Chicago Ave., Chicago IL 60611

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This form does not constitute legal advice and covers only federal law.

**ACKNOWLEDGEMENT OF RECEIPT OF
SMILES TO GO NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign This Acknowledgement**

I have received a copy of the Smiles To Go Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Patient's Name _____

Representative's Relationship to Patient _____

For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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This Form does not constitute legal advice and covers only federal law.

Smiles To Go Health History / Consent for Treatment
To be completed by a Parent or legal guardian

Patient's Last _____ First: _____ MI: _____

Date of Birth: _____ Gender: _____ School: _____

Address: _____

Street City State Zip
Parent(s) Last _____ First: _____ MI: _____

Phone: _____ Secondary Phone(cell/pager): _____

Emergency Contact Name: _____ Phone _____

Has your child ever seen a dentist before? Y N

If yes, when was the last time & name of the dentist _____

Is this child in need of EMERGENCY dental services (broken tooth, infection, bleeding) Y N

Does your child have or has your child had?

Asthma	Y	N	Congenital Heart Disease	Y	N
Heart Murmur	Y	N	Rheumatic Heart Disease	Y	N
Diabetes	Y	N	Bleeding Problems	Y	N
Seizures	Y	N			

If circled yes to any of the above, please explain: _____

What type of over-the counter pain reliever does your child take if needed? _____

Is your child taking any medications? Y N

What medications? _____

Does your child have any known allergies? Y N

If yes, please explain: _____

Has your child had any other serious illness or operation? Y N

What illness or operation? _____

Is there anything else we should know about the health of your child? Y N

List _____

Type of Dental Insurance: (circle one)

Mercy Care+ HealthCareUSA HarmonyHealth None Other: _____

If you do not have dental insurance, we will need proof of income WITH this application to verify your eligibility into our program.

Card # _____ (a copy of the card is needed before services will be given)

I give consent for my child to participate in the prevention and restorative dentistry program. To the best of my knowledge, the medical history questions have been answered correctly and accurately. I allow my child to receive local anesthetic (numbing of the teeth), preventative & restorative dental treatment (including but not limited to fillings, extractions, root canals, sealants, cleaning, and fluoride), and to be photographed while at the clinic. I also acknowledge that in some circumstances, it may be necessary to administer mild pain reliever to my child, I give consent to the dentist to administer mild pain medication at his discretion. I will follow directions given and fill any prescription necessary for my child

Name of Parent (Printed) _____

Signature _____ Date _____