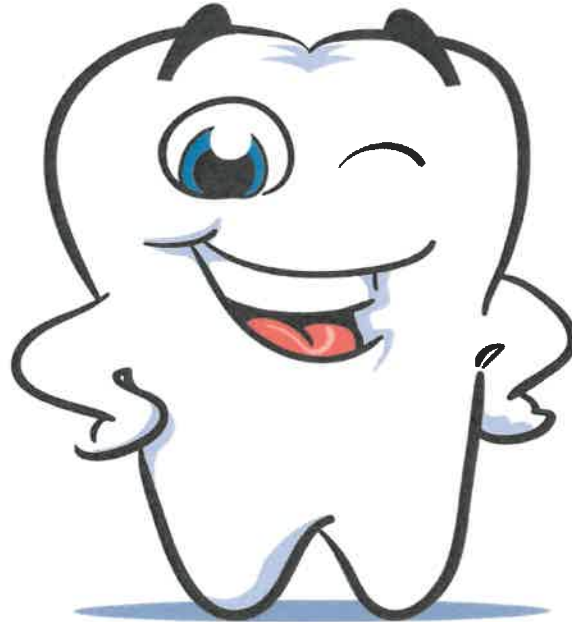
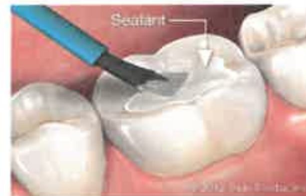
Kentucky River District Health Department

Dental Health Program



After completing the enclosed form your child may receive the following services by Kentucky River District Health Department Registered Dental Hygienist:

- Dental Sealants (cavity protection)
- Fluoride varnish
- Dental assessment
- Cleaning



MAKE SURE TO SIGN THE BACK OF CONSENT FORM!

Kentucky Public Health
Prevent. Promote. Protect.

Kentucky River District Health Department

Dental Health Program

*** THIS FORM MUST BE FILLED OUT COMPLETELY FOR YOUR CHILD TO PARTICIPATE***

With your **permission**, a public health dental hygienist will provide your child with:

- A dental assessment of the condition of the mouth and teeth
- Fluoride varnish (prevents future cavities on the smooth surfaces of teeth)
- Dental sealants (coatings over the cavity-prone grooved surfaces of back teeth)
- A professional dental cleaning
- Oral Hygiene Instruction including nutritional counseling
- Report Card, including follow up information

This program does **NOT** take the place of regular check-ups at a dental office. The preventive dental services are being done by a Public Health Registered Dental Hygienist without the on-site presence of a dentist, according to KRS 313.040. The Oral Health Director for the Kentucky River District Health Department, Nikki Stone DMD, who is supportive of the standards of practice of the public health hygienists and works with the Kentucky River District Health Department to develop and adopt protocols for these services.

(Check One)

__**YES,** I want my child to have preventive dental services at school

__**NO,** I do not want my child to have preventive services at school (if NO, Fill out Child's Name only)

Parent/Legal Representative Name (Please Print) ______________________________

Parent/Legal Representative Signature ______________________________

Daytime Phone: ____________________ Best way to be reached? (Circle one)

Cell Phone: ____________________ Daytime phone Other____________(please provide number)

Relationship to child______________________

Child's Name: ______________________________ (Circle one) Male Female

Child's Address: __________________________ **City:** ______________ **County:** _____________ **Zip Code:** __________

Date of Birth: ____/____/_____ **Child's Social Security Number** ________-_______-________

School ______________________________ **Teacher/Homeroom Teacher:** ___________________

What is your child's race: (Circle all that apply)

- American Indian/Alaskan Native
- Asian
- Black or African American
- Pacific Islander
- White

Ethnicity: -Hispanic or Latino

Does your child have Medicaid? (Circle one) YES or NO (**Medicaid will be billed for preventive services)**

Medicaid 10 Digit ID# _______________________ MCO # _______________________

Please mark which Managed Care Company you belong to with Medicaid:

_____Aetna Better Health of KY ________ WellCare ________ Passport ________Humana CareSource ________Anthem

Dental History:

Does your child have a dentist? (Circle one) YES or NO Dentist's Name ____________________________

Is your child experiencing dental pain at this time? (Circle one) YES or NO

When was the last time your child went to the dentist? (Circle one)

In the past year More than one year ago Never

*******Please Turn Form Over—Signatures required on second page.**

Health History: Child's Medical Doctor ____________________ Phone #____________

Please circle if your child has ever had: Heart Murmur Latex Allergy Other allergy __________________

Asthma Seizures/Epilepsy Diabetes Cancer/Chemotherapy Heart Problems (please explain) __________

Please list any other medical conditions (past or present) ______________________________

Please list *all* current medications taken regularly ______________________________

CONSENT FOR HEALTH SERVICES: (Expires 1 year from date signed)

Of my own free will I consent to care which may include, screening, assessments, preventive dental treatment, and any other health service given to me by staff or agents of this health department. I understand that no Guarantees are being made as to the effect of any assessments or treatment on me. I also understand I may be tested for (HIV) infection, Hepatitis B, or any other disease carried by blood or body fluids if a health care worker is exposed to my blood, body fluids or tissue.

This consent authorizes our providers to share pertinent information to ensure continuity of care. We may use medical information to provide, coordinate or manage your health care. We may consult with other health care providers, school administration, FRYSCs (Family Resource and Youth Service Centers) and/or MCO patient care coordinators concerning your or your child's need for care. Each party that is given personal health information is also bound by their signed agreements (HIPAA or FERPA) with their respective employers.

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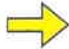
This form, when signed and filled in, contains Protected Health information and the information is to be protected according to the health Insurance Portability and Accountability ACT (HIPAA).
****My signature below acknowledges my receipt of the health department's **"NOTICE OF PRIVACY PRACTICES"** on the date stated.*

I understand that my child may be screened to check the retention of dental sealants by the public health dental hygienist during the following school year.



________________________________ ____________

Signature of Parent/Guardian or other Authorized Person *Date*

Signature of Patient or Other Authorized Person

Date

Please sign and date this section if you have Medicaid

PAYMENT FOR SERVICE/ASSIGNMENT OF BENEFITS

☐ ASSIGNMENT OF BENEFITS: I request that payment of authorized medical insurance benefits be made to the local health department on my behalf, for services received. I also authorize the local health department to release medical information about me to Medicare, Insurance and other third party payors to determine payment for services.

I have read the above and have had an opportunity to ask questions. I understand the above statement as it applies to me and my child. My signature below indicates I do consent, authorize or declare as stated above.

________________________________ ____________

Signature of Parent/Guardian or other Authorized Person *Date*

Signature of Patient or Other Authorized Person

Date

Please return to your child's classroom teacher or school nurse

Kentucky River District Health Department
NOTICE OF PRIVACY PRACTICES

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.

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice went into effect on September 20, 2013 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effectiveness for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established minimum necessary or need to know standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to see payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgement to disclose only that information directly relevant to your care. We will also use our professional judgement to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law (court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other state and federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing or for any fundraising purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Remainders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to phone calls, voicemail messages, e-mails, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be free for the initial set of copies. For each additional page we will charge $.50 per page. All other copies (photographs, drawings, etc.) shall be provided at cost. Advance payment for copies is required. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your healthcare information. When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available. You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2013. Information prior to that date would not have to be released.

Notification of Breach: Our agency is required by law to notify you in the event that any of your unsecured Protected Health Information is breached. You will be notified how the information was breached, the type of information breached along with instructions to reduce risk to you.

Restrictions: You have the right to place restrictions on our use or disclosure of your health information. We must agree on those restrictions and your request must be in writing. Any health information for services that you have paid for out of pocket can be restricted from health plans. Any restriction to your Protected Health Information that may result in our agency not being allowed to bill for services from a health plan could result in you paying out of pocket for services. You may contact our Privacy Officer with any questions.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing. Request a complaint form from our Privacy Officer. We support your right to the privacy of your information and 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.

HOW TO CONTACT US

Kentucky River District Health Department
441 Gorman Hollow Road Hazard, KY 41701

Telephone: (606) 439-2361
Fax: (606) 439-0870

Rev. 9/1/2013

Dental Sealants: Sealants are white protective coatings applied to the chewing surfaces of teeth to help keep them cavity-free. Sealants fill in the grooved surfaces of the teeth and prevent food particles from getting caught and causing cavities.

Sealants are fast and comfortable to apply and can effectively protect teeth for many years.

Fluoride Varnish: Depending on your oral health status and susceptibility to developing cavities, professional in-office fluoride treatments may be recommended every three, six, or twelve months. At KRDHD, we offer the lead fluoride treatment on the market to students. Our fluoride is painted on the tooth surface and virtually disappears after application unlike some older varnishes that appeared yellow. The varnish releases fluoride and calcium up to 24 hours after application ensuring maximum protection for your enamel surface.