Dental and Medical Mobile Program

School-Based Services
"Healthy Children Learn Better"

Dear Parent/Guardian:

Our school-based program increases access to care for students and families requiring primary dental and/or medical care. As your child gets older and grows, their medical and dental needs change. We recommend check-ups regularly, and this can prevent illnesses or ailments that would have been undiagnosed. Children's growing bodies need constant monitoring. The Dental and Medical program is a partnership between your child's school district and the Healthy Smiles Dental and Medical program of the Hampton Roads Community Health Center. If you enroll your child in this program, they will be **seen at your child's school during regular school hours** by a licensed dentist and/or hygienist for dental care to promote healthy teeth and gums. Medical care will be provided by a licensed physician and/or family nurse practitioner to administer school-required immunization shots and physicals.

Dental Services: May include a dental exam, x-rays, cleaning, fluoride treatment, sealants, and, if needed, referrals for prescriptions and dental emergencies. Fillings can be available after reviewing a treatment plan with the parent/guardian. We also provide each child with a goody bag with teeth-brushing supplies and educational information concerning oral health.

Medical Services: May include wellness examinations, vital signs, vision testing, hearing testing, immunization shots, and school and sports physicals. Each child will also receive a goody bag and educational information concerning healthcare issues for the season.

Dental and Medical Mobile Clinic: A brand-new health care Mobile is equipped with progressive medical and dental equipment, including exam tables and chairs, and following all regulations regarding appropriate sterilization, safety, and health procedures. Whenever your child is seen by the school-based dental or medical staff, a note is sent home that details the visit. You will receive information on your child's oral or medical health status and a list of the services provided during one or both visits.

Cost: No Cost to You!!! You are not responsible for payment of any service if your child is enrolled in a participating school. Your children are welcome to be treated at our fixed locations if needed. The Medicaid Smiles for Children program and FAMIS programs cover dental and medical services in the school setting. So, if your child has Medicaid or private medical or dental insurance, we will bill the insurance company and follow the billing requirements associated with your plan. However, if you do not have Medicaid or private insurance, your child can still receive "free" medical or dental care based on our arrangement with your child's school district.

Enrollment: Please complete the attached enrollment form and return it to the school nurse. If you have any questions about the dental or medical program, please contact the **Program Coordinator** at **757-553-7538, or leave a message at 757-397-0042 extension 550.**

We look forward to working with your child and the family this school year!

"We are the bridge to health care.

HAMPTON ROADS COMMUNITY HEALTH CENTER

NOTICE OF PRIVACY PRACTICES
EFFECTIVE APRIL 1, 2015

This Notice of Privacy Practices describes the personal information we collect, how and when we may use or disclose this information. It also describes your rights and our responsibilities related to your protected health information.

How will HRCHC use your Protected Health Information?

1. We will use your health information for treatment. Information obtained by the staff will be recorded in your medical record and used to determine the course of treatment that should work best for you. This information may be disclosed to other healthcare providers involved in taking care of your health needs.
2. We will use your health information for payment. A bill may be sent to you or your insurance company. The information on or with the bill may include information that identifies you as well as your diagnosis, procedures, and supplies used during your visit.
3. We will use your health information for regular health operations. Members of the quality improvement team may use information from your health record to assess the care and outcomes in your case and others like it. This information may then be used as we strive to continually improve the quality and effectiveness of the healthcare we provide.

Additional ways we may use your health information:

1. There are some services provided in our organization through contracts with business associates. We may disclose your health information to them, i.e., lab.
2. Unless you notify us that you object, we may use your name for directory purposes.
3. We may disclose information to notify a family member, a personal representative, or another person responsible for the care of your location and general condition.
4. We may disclose your information for research purposes when researchers have established protocols to ensure your privacy.
5. We may disclose information to organ procurement organizations for the purpose of tissue donation or transplant or to funeral homes.
6. We may contact you to provide appointment reminders or information about treatment alternatives for you.
7. We may contact you as a part of a fundraising effort.
8. We may use your information to enable product recalls, repairs, or replacements.
9. We may use your information to comply with laws such as workers' compensation or similar programs.
10. We may disclose your information to public health or legal authorities charged with preventing or controlling disease, injury, or disabilities.
11. We may disclose your information to correctional institutes or law enforcement.
12. We may disclose information as required by military command authorities or the Department of Veteran Affairs as may be applicable.
13. We may disclose health information about you necessary to prevent serious threats to your health and safety or the health and safety of another person. Disclosure would be for someone able to prevent that threat.
14. We may disclose health information to a health oversight agency for activities authorized by law.
15. If you are involved in lawsuits and disputes, we may disclose health information about you in response to a subpoena, discovery request, or other lawful process.

Your health information rights:

- Obtain a copy of this notice.
- Inspect and copy your health records.
- Amend your health record.
- Obtain an accounting of the disclosures of your health information.
- Request communication of your health information by alternative means.
- Request a restriction on certain uses and disclosures of the information,
- Revoke your authorization to use or disclose your health information.
- Confidential communication as to when and where we discuss your medical information.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care that we provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, amendment, or confidential communication, you must make your request in writing to the Privacy Officer. In your request, you must tell what information you want to limit and to whom the limits apply.

HRCHC is required to:

- Maintain the privacy of your health information.
- Provide you with this notice describing our legal duties and privacy practices.
- Abide by this agreement.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means.

Other uses of Health Information:

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permissions, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provide you.

HRCHC reserves the right to change our practices and to make the new provision effective for all the protected health information we maintain. Should our privacy practices change, we will provide you with a copy of the revised notice. We will not disclose or use your health information without your authorization (except as described in this notice). We will also discontinue to use or disclose your health information after we receive your written request.

For more information or to report a problem, contact the HRCHC Privacy Officer at 757-397-0042 x 354. You may also file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, NE, Room 509 F, HHH Building, Washington D. C., 20201. There will not be retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights. If you would like a detailed description of each of the items covered, please contact our Privacy Officer in writing, and a copy will be provided to you.

Acknowledgment of Receipt of this Notice

We will request that you sign a separate form or notice acknowledging that you have received a copy of this notice. If you choose or are not able to sign, a staff member will sign their name and date. This will be filed with your records.

HAMPTON ROADS COMMUNITY HEALTH CENTER

Dental and Medical Program **My child is a student at _____ School**

Student's Name _____ _____ _____
Last First Middle

Home address _____
Street City State/Zip

Country of Birth _____ Date of Birth _____

Social Security # _____

Race _____ Hispanic/Latino? ☐ Yes ☐ No ☐ Male ☐ Female

Grade _____ Teacher/Homeroom _____

Parent/Legal Guardian Name _____

Relationship to Student _____

Address (if different than student) _____

Phone: Home _____ Work _____ Cell _____

Email Address: _____

Additional Contact Information:

Name _____ Phone _____

Relationship to student _____

PLEASE SELECT ALL SERVICES NEEDED FOR YOUR STUDENT

☐ Dental ☐ Annual Physical ☐ Sports Physical ☐ Vaccinations

DATE OF LAST PHYSICAL _____ **DATE OF LAST DENTAL EXAM/CLEANING** _____

Please complete the following insurance information:

MEDICAL

Name of Insurance Company _____

Policy/Medical Assistance # _____ Group # _____

Insurance Billing Address _____

Policy Holder Name _____ Policy Holder DOB _____

Primary Care Provider (PCP) _____

DENTAL

Name of Insurance Company _____

Policy/Medical Assistance # _____ Group # _____

Insurance Billing Address _____

Policy Holder Name _____ Policy Holder DOB _____

Name of Dentist _____

I understand that my signature gives consent for the HRCHC school-based providers to provide preventative dental services, routine physicals, and vaccinations for my child and to communicate with the school nurse to facilitate care. If more extensive work is needed, the program will contact the parent before performing the treatment.

I understand that my signature indicates that I have received a copy of the Notice of Privacy Practices. I give HRCHC permission to call my home, leave a message on a machine, or with a person regarding healthcare information. HRCHC may also mail medical/dental care information to my home. I understand that my child's information will be used for treatment, payment, and healthcare operations. I recognize that school directories may be used to obtain information left blank on the enrollment form.

I understand that services provided to my child, if insured, will be billed to my insurance carrier or medical assistance, but never a cost to me.

Release for Use of Images *I hereby give my consent to Hampton Roads Community Health Center to photograph, videotape, and then use, reproduce, and publish said images of me and/or my child children with the intent of promoting healthy dental habits or activities.*

Parent/Guardian Signature _____ **Date:** _____

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HAMPTON ROADS
COMMUNITY HEALTH CENTER

School Year: _____

Students's Name: _____ **Date of Birth:** _____

List all medications your child takes daily or on a regular basis:

Medication:_____ mg: _____ Directions: _____

Allergies:

Medication ☐No ☐Yes Name of medication(s)_____

Reaction to medication(s) _____

Food Allergy ☐No ☐Yes Source of Allergy _____

Does your child have a doctor's order for an EpiPen? ☐No ☐Yes

DOES YOUR STUDENT HAVE/HAD ANY OF THE FOLLOWING CONDITIONS?	CHECK ALL THAT APPLY		ADDITIONAL INFORMATION TO HELP US BETTER SERVE YOUR CHILD'S NEEDS
Asthma or breathing conditions	Yes	No	
Attention-Deficit/Hyperactivity Disorder	Yes	No	
Bleeding conditions	Yes	No	
Cancer	Yes	No	
Depression or other Psychological conditions	Yes	No	
Developmental conditions	Yes	No	
Diabetes: Type 1 or Type 2	Yes	No	
Drug, Alcohol, or Tobacco use by Student/Household	Yes	No	
Hearing or Vision conditions	Yes	No	
Heart conditions ☐Congenital ☐Requires Antibiotics	Yes	No	
High Blood Pressure	Yes	No	
HIV/Aids	Yes	No	
Joint Replacement	Yes	No	
Lead poisoning	Yes	No	
Liver problems (Hepatitis)	Yes	No	
Seizure disorder (Epilepsy)	Yes	No	
Tuberculosis	Yes	No	
Any Other Health Issues:	Yes	No	
		Reviewed by	_____

VACCINATION STATUS: _____

PLEASE RETURN THIS FORM TO YOUR SCHOOL NURSE OR PARENT LIAISON