UNITY CARE NW's

MOBILE DENTAL PROGRAM

DENTAL SERVICES AVAILABLE

Dental Exam

Oral Health Instruction

Sealants

Fluoride

A written assessment of your child's oral health status and needs will be sent home after each visit.

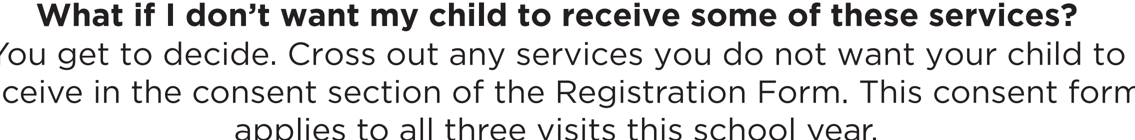
THERE WILL BE **NO COST TO YOU!**

If your child is insured, Unity Care will bill their insurance.
You will not be billed for services that are not covered.
All services are provided for free if your child has no dental coverage.

COMMON QUESTIONS

Do I need to be there?
You are welcome to attend, but not required to.

What if I don't want my child to receive some of these services?


You get to decide. Cross out any services you do not want your child to receive in the consent section of the Registration Form. This consent form applies to all three visits this school year.

I have other children who are not enrolled in school. Can they be seen?
Yes! Contact Dental Access Coordinator (below) to schedule.

OTHER QUESTIONS?

Contact **Robin Pearson**, Dental Access Coordinator:
(360) 788-2668 or ***robin.pearson@ucnw.org***

to REGISTER YOUR CHILD

Fill out the attached form and return it to their teacher

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.

Unity Care NW respects your privacy and we understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Example of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to and receive information from others providing you care. This will help your entire health care team stay informed about your care so we can effectively manage and coordinate your health needs.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care.

Information provided to health plans may include your diagnoses, procedures performed, and recommended care.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may contact you to raise funds, however you have the right to opt out of such fundraising communications with each solicitation.
- We may use and disclose your information to conduct or arrange for services, including:
  - medical quality reviews by your health plan;
  - accounting, legal risk management, and insurance services;
  - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing. We are not required to grant the request, but will comply with any request granted;
- You have the right to request restrictions on PHI disclosures to your health plan for health services or items paid out-of pocket in full and we must abide by your request.
- Request and receive from us a paper copy of the most current "Notice of Privacy Practices for Protected Health Information"
- Request that you be allowed to see and get a copy of your protected health information. You must make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information–except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. This statement will be stored in your medical record and included with any release of your records.
- Request a list of disclosures of your health information. This list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.
- You will receive notification of any breach of your unsecured Patient Health Information.

For help with these rights, please contact our Privacy Officer at the address indicated on the first page of this Notice.

Our Responsibilities

We are required to:

Give you this Notice upon request, follow the terms of this notice and keep your health care information private.

We have the right to change practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it, or by visiting our office to obtain a copy.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling or your protected health information, you may contact the Privacy Officer at the address shown on the first page of this Notice.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the Privacy Officer at the address shown on this Notice. You may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

To Remind You:

Unless you object, we may remind you in writing or by phone/voicemail that you have a health care appointment with us. These reminders may be made by postcard, phone, or voicemail unless you specifically ask us to communicate with you through a particular method.

We may use and disclose your protected health information without your authorization as follows:

- With Medical Researchers-if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- To Funeral Directors/Coroners consistent with applicable law to allow them to carry out their duties.
- To Organ Procurement Organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- To the Food and Drug Administration (FDA) relating to problems with food, supplements, and products.
- To Comply With Workers' Compensation Laws-if you make a workers' compensation claim.
- For Public Health and Safety Purposes as Allowed or Required by Law:
  - to prevent or reduce a serious, immediate threat to the health or safety of yourself or the public by communicating with your emergency contact or responding to questions posed by a close family/friend.
  - to public health or legal authorities
  - for public health and safety purposes. For example, we may share health information with the Health Department.
  - to prevent or control disease, injury, or disability
  - to report vital statistics such as births or deaths
- To Report Suspected Abuse or Neglect to public authorities.
- To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
- For Law Enforcement Purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- For Health and Safety Oversight Activities. For example, we may share health information with the Department of Health.
- For Disaster Relief Purposes. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- For Work-Related Conditions That could Affect Employee Health. For example, an employer may ask us to assess health risks on a job site.
- To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.
- In the course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.
- For Specialized Government Functions. For example, we may share information for national security purposes.

Unity Care NW does not currently use patient health information for marketing or sale, but if we were to do so, most uses and disclosures of health information for marketing purposes and most disclosure of health information that constitute the sale of this health information, would require your written authorization.

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

MOBILE DENTAL PROGRAM REGISTRATION FORM

Please **COMPLETE BOTH SIDES** of this form, **SIGN** the back page, and **RETURN** it to your school.

The Mobile Dental Program will make 2-3 visits during the school year.
Fluoride may be provided at the first visit or at either of the two follow up visits.

Please **CROSS OUT** any services you would **NOT** like your child to receive:

Visual Dental Exam	Oral Hygiene Instruction	Sealants	Fluoride Application

Questions? Call Dental Access Coordinator at **360-788-2668**

CHILD'S PERSONAL INFORMATION

List all children enrolled in the School District Elementary that you would like to register:

Child's Name (First and Last)	**Sex**	**Date of Birth**	**Teacher/ Elementary**
	❑ M ❑ F		
	❑ M ❑ F		
	❑ M ❑ F		

Mailing Address **Homeless?** ❑ *If yes, check box*

Language preference: ❑ English ❑ Spanish ❑ Russian ❑ Punjabi

Street or PO Box

City

State: WA

Zip Code: 98

Telephone Number

Email Address

CHILD'S MEDICAL AND DENTAL HISTORY

Does your child have any ongoing health problems? ❑ Yes ❑ No - *If yes, please describe and **include child's name:***

Child's Name

Health Problems

Does your child have any allergies? ❑ Yes ❑ No - *If yes, describe allergy, response and **include child's name:***

Child's Name

Allergies, Response

Is your child taking any medications? ❑ Yes ❑ No - *If yes, please list and **include child's name:***

Child's Name

Medications

Does your child see a dentist for an exam every 6 months? ❑ Yes ❑ No - *If yes, please list date and clinic:*

Approx. date of last exam

Dentist/Clinic Name

CHILD'S INSURANCE INFORMATION

Is your child currently covered by WA APPLE HEALTH or MEDICAID? ❑ Yes ❑ No

Provider One # ______________________________ You do not need to turn in a copy of your Provider One card.

Is your child currently covered by a Commercial Dental Insurance plan? ❑ Yes ❑ No

Insurance Company (Group Health, Premera, etc): ______________________________

Policy # (Individual ID on card): ______________________________ Group #:______________

Subscriber's Name: ______________________________ Relationship to child: ❑ Parent ❑ Other

Subscriber's Social Security #: ______ /______ /______ **Subscriber's Date of Birth:** ______ /______ /______

Please turn in a copy of your commercial insurance card with this form.

I authorized Unity Care NW or insurance company to release any information to process my claim

INFORMATION FOR GRANT PURPOSES ONLY

Unity Care NW is a Non-Profit Health Center that receives financial support from government and private grants.
This data is required to apply for funding and for reporting.

What is your child's ethnic background? ❑ Hispanic ❑ Non-Hispanic

What is your child's race? ❑ Asian ❑ Black/African American ❑ American Indian or Alaskan Native ❑ White
❑ Native Hawaiian ❑ Other Pacific Islander ❑ Refuse to Report

What is your child's primary medical insurance? ❑ Apple Health/DSHS/Medicaid ❑ Group Health ❑ Premera ❑ Regence
❑ Other ______________________________

Family Size (Number of people in household): ________

Monthly Income for Household (Approximate): ❑ Under $1,000 ❑ $1,000-2,500 ❑ $2,500-4,000 ❑ Above $4000

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record to get more information about it by contacting our Health Information Management Specialists at (360) 676-6177 ext 1112.
*Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.*

SIGNATURE REQUIRED FOR SERVICES

To the best of my knowledge, all of the preceding answers are true and correct. By my signature below, I give consent for my child to receive the provided services unless otherwise specified and to have my insurance billed for the services provided. I permit the sharing of information with school personnel, as needed. I also acknowledge receipt of the attached Notice of Privacy Practices.

Parent/Guardian's Name: (Please Print) ______________________ **Parent's Date of Birth:** ______ /______ /______

Parent/Guardian's Signature: ______________________________ **Date Signed:** ______ /______ /______

Relationship to Child: ❑ Mother ❑ Father ❑ Other: ______________________________