Sign Up Online!
SmileNYOutreach.com
Scan the code with your phone.

Member ADA American Dental Association®

IN-SCHOOL PRIMARY AND PREVENTIVE DENTAL CARE AT NO COST TO YOU

Our school, in partnership with Smile New York Outreach, is offering every child **PRIMARY AND PREVENTIVE DENTAL CARE AT NO COST TO YOU**. A licensed dentist or dental hygienist will regularly check your child's mouth and teeth as well as provide a cleaning, fluoride treatments, apply sealants as needed, and may take x-rays. A dental report will be sent home with your child.

COMPLETE AND RETURN THE PERMISSION SLIP BELOW.

☑ **YES**, I would like my child to have **PRIMARY AND PREVENTIVE DENTAL CARE AT NO COST TO ME**.

Child's Name _____ Birth Date _____ Male/ Female _____

Address _____ City _____ State _____ Zip _____

School _____ Teacher _____ Grade _____

Parent/Guardian Name _____

Email _____ Phone _____

Emergency Contact Name
(if different from Parent/Guardian information above) _____ Phone _____

IMPORTANT HEALTH QUESTION
Does your child have any past or present medical or dental conditions or disabilities? This may include heart issues, breathing problems, brain/seizure disorders, allergies (including food or drug allergies), diabetes, bleeding problems, communicable diseases (including COVID-19) or immune disorders etc. If Yes, explain below (attach additional pages as needed). IF NO, LEAVE BLANK.

_____

_____

☐ **MY CHILD HAS CHILDREN'S MEDICAID/CHILD HEALTH PLUS:** Affinity Health Plan, CDPHP, Empire Blue Cross Blue Shield, HIP/Emblem, Healthfirst, Fidelis Care, MetroPlus Health Plan, MVP, UnitedHealthCare

Enter Child's Children's Medicaid/ Child Health Plus ID Number: _____

EXAMPLE A B 1 2 3 4 5 C

OR Child's Social Security # if Medicaid number is not available ☐☐☐ – ☐☐ – ☐☐☐☐

☐ **MY CHILD HAS PRIVATE DENTAL INSURANCE:**

Ins. Company Name (not Medicaid) _____ Ins. Phone _____

Group # _____ Employer name _____ Co. phone _____

Insured Adult Name _____ **Insured Adult Birthdate** _____

Member ID/Policy # _____ Insured Adult SS # _____

I understand and authorize Smile New York Outreach LLC (Provider), its affiliated dentists or dental hygienists, to provide dental services at school to the above named child for whom I am the custodial parent or legal guardian, including an exam, cleaning, fluoride, sealants, x-rays and the application of Silver Diamine Fluoride as needed. (The use of Silver Diamine Fluoride may discolor any cavities to a brown or black color. SEE BACK FOR DETAILS.) I have read the IMPORTANT HEALTH QUESTION above and will report any significant changes in my child's health to 855-481-8638. I have read the IMPORTANT NOTICE AND CONSENT ON THE BACK OF THIS PAGE and understand and agree to its terms.

SIGN HERE Parent/Guardian Signature _____ Date _____

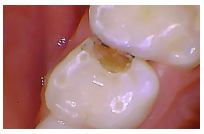
This consent authorizes the initial and future dental visits.

Smile New York Outreach LLC
1808 Crotona Parkway, Bronx, NY 10460

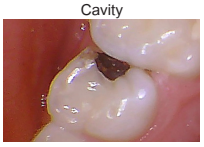
IMPORTANT NOTICE AND CONSENT

I consent for my child to receive oral health care services provided by the State-licensed health professionals of Smile New York Outreach LLC as part of the school oral health program approved by the New York State Department of Health for as long as my child is enrolled at school. I understand and authorize Smile New York Outreach LLC (Provider) and its affiliated dentists and dental hygienists to provide the following services to the named child for whom I am the custodial parent or legal guardian: dental exam & oral hygiene instruction, teeth cleaning, fluoride treatment, x-rays & dental sealants, as well as the application of Silver Diamine Fluoride to treat the progression of tooth decay. I understand that a portion of my child's dental examination may be performed remotely and that clinical information (such as x-rays) may be collected and sent electronically to another site for the dentist's evaluation. I consent to these teledentistry services and understand that while confidentiality protections apply, the use of third party electronic transmissions may present additional privacy risks. I understand that I have the right to access medical information related to teledentistry services. I authorize & direct Provider to bill and collect payment from any Medicaid, insurance, or other payor, if any, as well as to release my child's information to any responsible payor and/or administrative service provider and their subcontractors for use and disclosure relating to my child's treatment, payment for services and health care operation purposes. (I consent to the Provider sending text messages about the school dental program. I acknowledge that text messaging is not a secure form of communication and presents additional privacy risks. (Message and/or data fees may be charged by your wireless service provider; to discontinue, reply "STOP" to any message received from us. You also agree to receive pre-recorded and/or auto-dialed telephone calls relating to the school dental program at the land-line and/or mobile telephone numbers provided on this consent form.) I have received the Notice of Privacy Practices on the top of this form. This signed consent authorizes my child's initial and future dental visits. I may withdraw this consent at any time in writing.

Silver Diamine Fluoride (SDF) - A new dental treatment to fight cavities



Cavity



SDF applied

BENEFITS OF SDF: Dental cavities are common in children, but now our dentists have a safe, painless alternative to traditional cavity drilling procedures called silver diamine fluoride (SDF). SDF is an FDA-approved antibiotic liquid used to help prevent cavities from forming, growing, or spreading to other teeth. The dentist simply brushes SDF on back teeth only.

Alternatives

- No treatment: The tooth may continue to decay and cause pain.
- Other options: fluoride varnish, a filling or crown, or extraction of the tooth.

Risks

- SDF treatment may not eliminate the need for a traditional filling.
- It's normal for SDF to stain the cavity brown or black–it means it's working.
- The healthy parts of the tooth will not be stained.
- SDF can cause temporary staining if it comes into contact with skin. The stain is harmless and should disappear in less than a week.
- SDF may cause a temporary metallic taste.

Questions? Call one of our care coordinators at 855-481-8638.

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. KEEP FOR YOUR RECORDS

OUR LEGAL DUTY

The privacy of your medical information is important to us. 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. We will notify you if your unsecured medical information is breached.

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, school nurse/healthcare coordinator, 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 business operations such as reviewing the competence or qualifications of healthcare professionals and evaluating practitioner and provider performance.

Your Authorization: Uses or disclosures not otherwise described in this Notice may be made only with your written authorization. In addition, we must obtain your written authorization to sell your medical information or to use or disclose your information for marketing goods or services to you where we are paid to make the communication. 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 and Persons Involved in Your Care: We may disclose your health information to a family member, friend or other person involved in your care to the extent necessary to help with your healthcare or with payment for your healthcare. We may also disclose your medical information to disaster relief organizations to help locate individuals during a disaster. We may also use or disclose your medical information to notify, or assist in the notification, of a family member, a personal representative or a person responsible for your care of your location, general condition or death. If you do not want us to disclose your medical information to family members or others in these circumstances, please notify our HIPAA Officer at 888-833-8441.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Safety: We may need to disclose medical information to law enforcement officials, such as in response to a search warrant or a grand jury subpoena, or to assist law enforcement officials in identifying or locating an individual, to report deaths that may have resulted from criminal conduct, and to report criminal conduct on our premises.

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.

reminders (such as voicemail messages, postcards, letters, emails or text messages).

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure surveys. These activities are necessary for the government to monitor the health care system, the outbreak of disease, government programs, compliance with civil rights laws and to improve patient outcomes.

Lawsuits and Disputes: We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process.

Other Uses and Disclosures. As permitted or required by law, we may use or disclose your medical information for research purposes; to organizations that handle and monitor organ donation and transplantation; for workers' compensation or similar programs to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness; for public health activities such as to prevent or control disease, injury or disability; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to, or is at risk for contracting or spreading a disease; to medical examiners to identify a deceased person or determine cause of death; or to funeral directors to carry out their duties.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information and fax your request to the number at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of some disclosures we or our business associates have made of your health information. 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 restrict our use or disclosure of your health information. We are not required to agree to your request except when disclosure would be to your health plan, you (or someone on your behalf other than your health plan) has paid in full for your health care, the disclosure relates to payment or health care operations, and the disclosure is not otherwise required by law. If we agree to the restriction, however, we will abide by that agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations specified in your written request.

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

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, 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 Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: HIPAA Officer
Phone: 888-833-8441 Fax: 888-330-4331 email: HIPAAOfficer@mobiledentists.com
Effective Date: November 1, 2022

PATIENT'S BILL OF RIGHTS

As a patient of Smile New York Outreach, you have the right to:

1. Understand and use these rights. If for any reason you do not understand or you need help, the Center must provide assistance, including an interpreter.
2. Receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or source of payment.
3. Be treated with consideration, respect and dignity including privacy in treatment.
4. Be informed of the services available at the Center.
5. Be informed of the provisions of off-hour dental emergency coverage.
6. Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care.
7. Receive an itemized copy of his/her account statement, upon request.
8. Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.
9. Receive from his/her dentist information necessary to give informed consent prior to the start of any non-emergent procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the risks involved, and alternatives for care or treatment, if any.
10. Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action.
11. Refuse to participate in experimental research.
12. Express complaints about the care and services provided and to have the Center investigate such complaints, without fear of reprisal. A patient may express their concern verbally or in writing to the administrator. The Center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The Center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the Center's response, the patient may complain to the New York State Department of Health's Office of Health Systems Management by calling 800-804-5447.
13. Privacy and confidentiality of all information and records pertaining to the patient's treatment.
14. Approve or refuse the release or disclosure of the contents of his/her dental record to any healthcare practitioner and/or healthcare facility except as required by law or third-party payment contract.