Keys AHEC
Health Centers

Dental Services

Dear Parent/Guardian,

Keys AHEC is proud to announce the ability to provide Full Service Dentistry at selected Monroe County Public School sites.

The **KEYS AHEC HEALTH CENTERS** will offer basic oral health care that may include basic preventative and restorative dentistry and treatment. These services are provided to children enrolled in Monroe County Public Schools. Keys AHEC may also bill insurance companies and Medicaid, where applicable. A small encounter fee may be accessed that covers all visits until the treatment plan is complete.

All services require parental consent. Should you want your child to receive oral health services when they are needed, you must sign the **Patient Registration, Patient History and General Consent for Treatment Form.** Please fill out all sections with the requested information. The General Consent for Clinical Treatment must be signed and dated by the child's parent or legal guardian.

It is important that you return the completed and signed **Patient Registration, Patient History and General Consent for Treatment Form** to the AHEC Clinic or to the Dental team at the time of visit or as soon as possible. This will ensure that your child is able to receive services when they are needed and without any delay.

After the Health Center receives the signed **Treatment Forms**, your child will be allowed to receive the designated care services provided by **Keys AHEC HEALTH CENTERS-Dental Program**. Please contact the Dental Office at**: 305-743-7111 ext 220** with any questions that you may have.

Sincerely,

Michael Cunningham

Michael Cunningham
CEO Keys AHEC

Keys AHEC
Health Centers

Attention to our Insured Patients

While Keys AHEC Health Centers may bill your insurance company, **there are NO deductibles, coinsurance, copayments, or similar charges required of you as our patient in relationship to your insurance.**

However, on behalf of your insurance company you may receive:

An **explanation of benefits** (commonly referred to as an **EOB** form) which is a statement sent by your health insurance company explaining what treatments and/or services were paid for on your behalf.

You may also receive information on your **deductible** which is the amount you would typically have to pay **out-of-pocket** for expenses before your insurance company will cover the remaining costs.

Because Keys AHEC waives all insurance related expenses

YOU ARE NOT RESPONSIBLE FOR THIS OR ANY OTHER FEES.

Keys AHEC
Health Centers

CHILD HEALTH HISTORY – HEALTH HX

Patient Information (Confidential) Today's Date: _____
Patient Name:_____
Date of Birth: _____ Age: _____ Gender at Birth:_____
Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____
Cell: _____ Accept text: Y N
Email: _____
Patient SSN:_____ Race:_____
School Attended:_____Grade:_____
Child's Primary spoken language:_____
What is the reason for today's Visit:_____

Number of People in the Family:_____

Family Annual Income Range: (Check One)

_____Under $20,000 _____$20K -$35K _____$35K-$50K _____$50K-75K _____$75K to $100K _____Over $100K

PARENT/GUARDIAN #1
Name: _____
Relationship to Patient:_____
Date of Birth: _____
*If Different from Patient Above
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____ Ext: _____

PARENT/GUARDIAN #2
Name: _____
Relationship to Patient:_____
Date of Birth: _____
Relationship to Patient:_____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____ Ext: _____

PARENT GUARDIAN EMAIL:_____

DENTAL INSURANCE INFORMATION PRIMARY

DENTAL COVERAGE
Insurance Company:_____
Phone Number: _____
Group/Policy Number: _____
Subscriber Name: _____
Subscriber ID: _____
Subscriber Date of Birth: ____/_____/_____
Subscriber SSN: _____-____-_____

CHILD HAS MEDICAID:
Insurance Company:_____
Medicaid Number: _____

***Please Provide Copy of the Insurance Card of any Insurance or Medicaid.**

MEDICAL HISTORY

Please describe the patient's current health:

Excellent _____Good _____Poor _____ Height:_____ Weight:_____

Please list all medications the patient is currently taking:

MEDICATION	DOSE	DIRECTIONS

Please list any known allergies:_____

Is the patient currently under the care of a physician? Y N Date of Last Visit: _____
Physician: _____ Office Number: _____

Has your child ever been diagnosed with or treated for the following?

Y N	ADHD/hyperactivity	Y N	breathing problems	Y N	heart murmur	Y N	premature birth
Y N	allergies	Y N	cancer/tumor	Y N	hepatitis	Y N	rheumatic fever
Y N	anaphylactic reaction	Y N	cerebral palsy	Y N	high blood pressure	Y N	seizures/epilepsy
Y N	anemia	Y N	cleft lip/palate	Y N	HIV/AIDS	Y N	sleep apnea
Y N	arthritis	Y N	delayed speech	Y N	kidney disease	Y N	sickle cell disease
Y N	artificial joints	Y N	developmental delay	Y N	latex sensitivity	Y N	sinus problems
Y N	asthma	Y N	diabetes	Y N	liver disease	Y N	STD
Y N	birth defects	Y N	fainting spells	Y N	low birth weight	Y N	tonsillectomy
Y N	bladder disease	Y N	head/neck injury	Y N	mental/nervous disorder	Y N	tuberculosis
Y N	bleeding problems	Y N	hearing impairment	Y N	pacemaker	Y N	vision problems
Y N	blood disorder	Y N	heart condition	Y N	pregnancy	Y N	other

If other, please specify: _____

When was your child's last dental visit?_____

Previous dentist's name and/or agency:_____

When were X-rays last taken of your child's teeth? _____

Y N	Do you have any concerns regarding his/her teeth?	Y N	Does your child use dental floss?
Y N	Do you supervise or assist your child in brushing his/her teeth?	Y N	Does your child use fluoride tablets or rinses?
Y N	Does your child have any tooth, jaw, or muscle discomfort?	Y N	Does your child use toothpaste with fluoride?
Y N	Does your child only drink bottled, highly-filtered, or well water?	Y N	Does your child get cold sores or canker sores?
Y N	Does your child have a click, pop, or other noise in the jaw joint?	Y N	Does your child clench or grind his/her teeth?
Y N	Does your child frequently eat sweets and/or drink juices or sodas?	Y N	Does your child have frequent headaches?
Y N	Are any of your child's teeth uncomfortable for him/her when he/she bites?	Y N	Are your child's teeth sensitive to hot or cold?
Y N	Do your child's gums bleed when brushing or flossing?		
Y N	Does your child have any concerns about the appearance of his/her teeth?		
Y N	Does your child have a history of an accident or injury involving the teeth/jaws?		
Y N	Does your child have a habit of snoring or mouth breathing?		

Y N Does your child have a current or previous habit involving a pacifier or thumb/finger sucking?

Y N Did your child have a history of going to sleep with a baby bottle or on demand breast feeding?

How has your child reacted to previous dental procedures?_____

How do you expect your child to react in the dental chair?_____

What are your child's interests and hobbies?_____

I, the undersigned parent/legal guardian of this child, certify that the above is accurate and complete to the best of my knowledge. I will notify the doctor(s) and/or the staff of ***any*** change in the above prior to ***any*** appointment.

Signature:_____ Name:_____

Date: _____ Relationship to Patient:_____

CONSENT FOR DENTAL TREATMENT

I, the undersigned parent/legal guardian, hereby give consent for the doctor(s) and/or clinical staff to examine this child, clean his/her teeth, perform all necessary dental treatment, administer local anesthetics, administer medications, apply topical fluoride, take diagnostic radiographs (X-rays), take clinical photographs, obtain study models and other records necessary for an accurate diagnosis for my child. I understand that dental treatment for children involves behavior guidance, which may include the use of praise, explanation and demonstration of procedures and instruments, variable voice tone, mouth props, nitrous oxide (laughing gas), or protective stabilization when necessary to promote cooperative behavior and a positive experience and to protect my child from potential injury.

Parent Signature_____Date_____

Parent/Guardian may elect for Keys AHEC to see the child without a parent present with additional consent. Parent/Guardian will be called before any Invasive Service is provided for permission.

_____ I consent to have my child seen without being present.

IN OFFICE POLICY

We reserve your appointment time specifically for you. Please arrive early for all appointments. If you need to reschedule, please give at least 48 business hours notice so we may give someone else the opportunity to use that time. A fee may be charged for late late cancellations, and missed appointments.

All children must be accompanied to all appointments by one adult aged 18 or older. This one adult must remain on the premises during the entire appointment. Multiple missed appointments may result in Keys AHEC not scheduling future appointment for the child.

Cell phone, tablet, and other electronic device usage is prohibited during appointments. The use of cameras, audio, and video recording devices is prohibited without express written consent.

Authorization
Non-Parent/Guardian to Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren). The person bringing your child will need to present a legal photo identification at time of service.

This authorization gives the person permission to bring your child (ren), talk with the doctor, give authorization for treatment, and make general health and financial decisions.

I,_____, give the person(s) listed below permission to accompany my child to Keys AHEC and to discuss and share medical/dental information about my child. I further authorize them to see all necessary medical records and make decisions of a routine nature in a dental office as determined at the sole discretion of the doctor.

Child's Name:_____D:O:B_____

Child's Name:_____D:O:B_____

Child's Name:_____D:O:B_____
(IF ONLY PARENT ARE ALLOWED TO BRING CHILD(REN)IN, PLEASE INDICATE "NONE")

_____ _____
Name of person allowed to bring child Relationship

_____ _____
Name of person allowed to bring child Relationship

_____ _____
Signature (Parent/Guardian) Date

_____ _____
Treating Doctor Signature Date

FINANCIAL POLICY

To avoid any questions regarding our financial policy, please read the following statements carefully:

****PAYMENT OF $10 IS DUE PRIOR TO SERVICES RENDERED and is expected before treatment *regardless* of any insurance involvement.****

****There will be a charge of $10 for a broken appointment or cancellation with less than 24 hours notice for your appointment****

*We accept Cash, Debit Cards, MasterCard and Visa with valid ID. No personal checks accepted.
*Financing is available through Care Credit for treatment. Patients may enroll at CareCredit.com. Any account over 90 days is considered delinquent and could be subject to third party collection. Any fees associated with third party collection are the responsibility of the parent/guardian.

HIPAA
In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), personal identifiable information will be used for, but not limited to, the following: treatment; to obtain pre-treatment authorization or payment from dental insurance; to obtain records from previous dental office; referral to a specialist; referral to a surgery center and associated anesthesiologist; electronic claims submissions; fax transmissions; sign in sheets; appointment reminders or recall cards; or for third party collection on delinquent accounts. A full disclosure of HIPAA statement is available at the front desk and is posted in the office. We use business associate agreements with any company that may come in contact with your health information. This business associate agreement is an agreement on their part to keep your information private and protected.

FOR PATIENTS WITH DENTAL INSURANCE: Due to the HIPAA laws, we are provided *general* information only about your dental policy. Your child's previous dental history is not disclosed when verifying eligibility. *It is the parent/caregiver or adult patient's responsibility* to notify the office of previous dental procedures such as bitewing films, panoramic films and sealants. We accept no responsibility if your insurance denies payment**.** Our office assumes no responsibility for ANY insurance information received, including but not limited to the allowable benefits; limitations; restrictions; exclusions; termination date; or 'cobra' status of a policy. Dental insurance is a contract between the subscriber and the insurance company, not the dental office. It is the responsibility of the subscriber/parent to understand their dental policy and limitations, restrictions or exclusions cobra status or termination date specific to that policy. This information is available from the Human Resource department, directly from the dental carrier or in the policy handouts provided by the employer

IF YOUR INSURANCE IS NOT LISTED ABOVE, we may be out-of-network with your dental carrier. Contact your dental carrier to verify our 'network' status. If you are out of network, we may still be able to treat the patient. Out of network benefits are assigned to the patient not the provider therefore the entire cost of dental treatment will have to be paid up front, any dental benefits will be sent to the subscriber by the insurance company. All co-payments for out-of-network plans are *estimated* and based on a 'reasonable and customary' fee schedule utilized nationally by dental carriers for "out of network" providers. Estimated co-payments are due at the time of visit. If your (or your child) requires extensive dental treatment, our office will submit a pre-treatment estimate prior to initiating treatment. ***You will be responsible for ANY balance not covered by your dental carrier. Any disputes are handled by the subscriber directly with their insurance*.**

PRE-TREATMENT ESTIMATES are never a guarantee of benefit or payment. **Actual benefit is not determined until your insurance receives a treatment claim for final processing**. Most insurance companies have specific guidelines regarding payment for procedures. Dental benefits are based on your yearly maximum allowance, deductible, and any limitations, restrictions or exclusions specific to your policy, and the fee schedule established by your dental carrier. Also, many insurance companies have a 'maximum allowable' per procedure which may be less than the fees submitted by our office. **The patient, parent or guardian is responsible for ANY remaining balance unless otherwise determined by a participating provider contract**

as stated above. If you have dual coverage, the secondary carrier will base payment on the 'coordination of benefits' clause. Dual insurance does not guarantee payment in full for treatment. Read the information offered by your insurance to understand coordination of benefits clause.

Insurance claims or pre-treatment estimates are submitted as a courtesy to our patients. The filing of your dental claim in no way reduces your personal or financial responsibility or obligation to the office. We will resubmit claims one time if an insurance company does not respond with an authorization or payment within 60 days. Regardless of a patient's affiliation with a specific dental insurance or the type of dental coverage, the patient and/or subscriber are ultimately responsible for **ANY** unpaid balance.

I have read, understand and accept the financial policy contract. I understand and fully accept the financial responsibility for myself/my child/children's account. I understand and fully accept that I am responsible for ANY balance on the account regardless of my involvement with any dental insurance. If I am insured, my signature allows for assignment of benefits directly to Steven DeLisle DDS PC. This agreement covers but is not limited to consults, exams and treatments performed from the initial date up to 1 (one) year.

PATIENT PRIVACY & DISCLOSURE AUTHORIZATION - HIPPA

OUR PRIVACY PLEDGE

We respect your privacy. Other than the necessary uses and disclosures we describe, we will not sell your health information or provide any of your health information to any outside marketing company.

USES & DISCLOSURES

Below you will find examples of how we may have to use or disclose your health care information:

a. Your doctor or a staff member may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.
b. It may be necessary for our insurance and/or billing staff to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, your employer, a family member, other relative or close personal friend, who is involved in your care or to facilitate the payment related to your care.
c. It may be necessary to use your health information, examination and treatment records / billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
d. It may be necessary to use your information (ex. Name, address, phone number, and your clinical records) to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interested to you. 164520(b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

*Note, as our patient you do possess the 'right to refuse' our office to contact you regarding the above-mentioned circumstances. However, if you do not give us authorization, it could affect the methods we use to obtain reimbursement for your care.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. If we are providing services to you based on the orders of another health care provider.
2. If we provide health care services to you in an emergency or disaster relief situation.
3. If we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
4. If we provide health care services to you as a result of a Worker's Compensation injury.
5. If you are/were a member of the armed forces, we are required by military command authorities to release your health information.
6. If we provide health care services to you as an inmate.
7. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances above, any other use or disclosure of your health information will only be made with your written consent.

Your right to revoke your authorization

You may revoke your privacy release authorization from us at any time. However, your revocation must be in writing. You can call for information about revoking your authorization during normal business hours, or send your request to the address above. There are two circumstances under which we will not be able to honor your revocation request.

1. If we have already released your health information before we have received your request to revoke authorization. 164.508(b)(5)(i).
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, a written statement must be received at Sedation Dental Center of Las Vegas.

Your right to limit use or disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know in writing what individuals or organizations to whom you do not want us to disclose your health information. We are not required to agree to your restrictions. However if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

We normally provide information about your health to you in person at the time you receive services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information
You have the right to inspect and copy your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information be in writing.

Your right to amend your health information
You have the right to request that we amend your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make. Your right to receive an accounting of the disclosures we have made of your records.

You have a right to request that we give you an accounting if the disclosures we have made of your health information for the last six years before the date of your request. This accounting will include all disclosures except:

a. Those disclosures required for your treatment, to obtain payment for your services or to run our practice.
b. Those disclosures made to you.
c. Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved in your care.
d. Those disclosures made for national security or intelligence purposes.
e. Those disclosures made to correctional officers or law enforcement officers.
f. Those disclosures that were made prior to the effective date of the HIPPA privacy law.

Our duties
We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change in our privacy terms the change will apply for all of our health information in our files.

Re-disclosure
Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

For more information or to report a problem
If you have any questions and would like additional information, you may contact our practice in writing. If you believe your privacy rights have been violated, you can either file a complaint with Keys AHEC at:

Michael Cunningham, CEO
5800 Overseas Hwy, #38
Marathon, FL 33050
michael@keysahec.org 305 743 7111 ext 202

Parent Guardian Signature **Date**