Orland Park Dental Services

Helping Kids... Because We Care

Enclosed is a permission slip for a ***FREE*** dental exam for this school year available to ALL students. Licensed Dentist and Hygienists will be coming into your child's school to examine the children. All children who sign-up for this program will receive a dental exam. Eligible children will also receive a cleaning, fluoride treatment and sealants (if needed). Sealants are the protective coating on the chewing surfaces of the back teeth.

*****Please note this program is for ALL grades but state law requires K, 2nd, 6th and 9th graders have a mandatory dental exam prior to May 15th of this school year. This dental exam will fulfill this requirement. State forms will be filled out and left with the nurse's office.***

A form will be sent home with every child we see explaining what services were performed and if further treatment is needed. Please fill out the top portion of the permission slip, ***SIGN*** the form and have your child return it to school. If you are NOT INTERESTED in this program, please put your child's name on the form and put an 'X' on the form so we know that you are not in need of this service.

Thank You!

ORLAND PARK DENTAL SERVICES, LTD (OPDS) NOTICE OF PRIVACY PRACTICES GARDING PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Uses and Disclosures of PHI: We may use PHI for the purposes of treatment, payment and health care operations, in most cases without your written permission. Examples of our use of your PHI:

- For Treatment. This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment, and may transfer your PHI via radio or telephone to the hospital or dispatch center.
- For Payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations and collecting outstanding accounts.
- For Health Care Operations. This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.

Use and Disclosure of PHI without Your Authorization. We are permitted to use PHI without your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including:

- For the treatment, payment or health care operations activities of another health care provider who treats you;
- For health care and legal compliance activities;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interests;
- To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence;
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when responding to a warrant;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- For research projects, but this will be subject to strict oversight and approvals;
- Use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

Patients Rights: As a patient, you have a number of rights with respect to your PHI, including:

- The right to access, copy or inspect your PHI. This means you may inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee, as state law permits, to provide a copy of any medical information you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have forms available to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. You also have the right to receive confidential communications of your PHI. If you wish to inspect or obtain a copy of your medical information, you should contact our local privacy representative.
- The Right to Amend Your PHI. You have the right to ask us to amend written medical information we may have about you. We will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct. If you wish to request an amendment of the medical information we have about you, please contact our local privacy representative to obtain an amendment request form.
- The Right to Request an Accounting. You may request an accounting from us of certain disclosures of your medical information we have made in the six years prior to the date of your request. However, your requests for an accounting of disclosures cannot precede the implementation date of HIPAA April 14, 2003. We are also not required to give you an accounting of our uses of PHI for which you have already given us written authorization. If you wish to request an accounting, contact our local privacy representative.
- The Right to Request That We Restrict the Uses and Disclosures of Your PHI. You have the right to request that we restrict how we use and disclose your medical information we have about you. We are not required to agree to any restrictions you request, but any restrictions agreed to by us in writing are binding on us.
- If you would like a paper copy of this Notice, you may contact us at the address listed below and we will provide you a paper copy of the Notice upon request.

Revisions of the Notice: We reserve the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all PHI we maintain. You can get a copy of the latest version of this Notice by visiting our office and picking up a copy.

Your Legal Rights and Complaints: If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact OPDS, Ltd. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Orland Park Dental Services, Ltd. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Effective Date of the Notice: April 14, 2003

(7B)

DENTAL SCREENING… PLEASE RETURN AS SOON AS POSSIBLE

PLEASE PRINT IN INK!!!

NAME OF SCHOOL: ______________________
TEACHER: ______________________ GRADE: __________
COUNTY: ______________________

If you are not interested in this program, please print your child's name and put "NO" on this form.

Dear Parent or Guardian,

OPDS, Ltd. and The Illinois Department of Public Aid have arranged for dental services for eligible children. These services may include an exam, cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists, hygienists and assistants will come to your child's school with portable equipment. In order for your child to receive these services **YOU MUST PROVIDE ALL THE INFORMATION REQUESTED BELOW AND SIGN IN THE AREA INDICATED.**

Your child's name ______________________ Birth date ____/____/____ Home Phone ( )____-____ Gender: Male / Female
Please Print
Address: ______________________ City ______________________ Zip: ______________

DOES YOUR CHILD HAVE ANY MEDICAL HISTORY THAT MAY COMPLICATE DENTAL TREATMENT?
Heart murmur ________: Latex allergy ________: Blood disorder ________: Other ______________

DENTIST'S INITIALS
Reviewed Health History
____

DOES YOUR CHILD **QUALIFY** FOR **FREE AND REDUCED MEALS** Yes No
# of family members ________ Income per year (optional) ______________

IS YOUR CHILD ENROLLED IN THE "ALL KIDS" PROGRAM (PUBLIC AID/MEDICAID/KID CARE)? Yes No

If YES, Include your child's RECIPIENT ID NUMBER ___ ___ ___ ___ ___ ___ ___ ___ ___
9 DIGIT ID NUMBER ON BACK OF MEDI-PLAN CARD

IS YOUR CHILD COVERED BY **PRIVATE** DENTAL INSURANCE Yes No

ETHNICITY: Hispanic____ Non Hispanic____ RACE: White____ African American____
American Indian/Alaska native____ Asian/Pacific Islander____ Other____ Unknown____

DENTIST'S INITIALS
Reviewed Signature
____

****Signature:** ______________________ **Date:** ______________

PARENT OR GUARDIAN MUST SIGN TO PARTICIPATE!!!!!!

****In signing this form, you are giving permission to treat your child and also verifies that you have read the back of this form regarding HIPAA.**
****This will also give permission for IDPH, QA Audits and providers to return to your school and re-check your child's sealants.**

DO NOT WRITE BELOW THIS LINE **(rev. 03/11)**

TO BE COMPLETED BY DENTIST

Prior Restorations – Prior Sealants

Sealants Present	____	YES	____	NO (Prior to exam – 1st molars only)		
Caries Experience	____	YES	____	NO		
Untreated Caries	____	YES	____	NO		
Oral Hygiene Status	____	GOOD	____	FAIR	____	POOR
Periodontal Status	____	GOOD	____	FAIR	____	POOR

CURRENT DENTAL STATUS OF PATIENT:

TREATMENT NEEDED

DECAY	SEALANTS Placed Today

SCORE ________

ORAL HEALTH ASSESSMENT RATING

1. Preventive Care (services rendered today) – There is no visual evidence of caries activity or periodontal pathology.
2. Restorative Care – Amalgams, composites, crowns, etc.
3. Urgent Treatment – Abscess, nerve exposure advanced disease state, signs or symptoms that include pain, infection or swelling.

Dentist/Hygienist Signature ______________ / ______________
(Reviewed Name/D.O.B)

Treatment Date: ______________ **Dentist's Signature:** ______________________

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