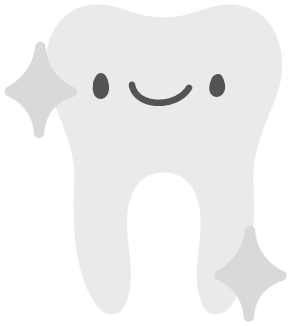
COVENANT COMMUNITY CARE
MOBILE DENTAL
SCHOOLS CONSENT FORM

SCHOOL BASED DENTAL SERVICES

- Dental Exam
- X-rays
- Fillings
- Extractions *(baby teeth)*
- Teeth Cleaning
- Fluoride Treatment
- Sealants *(on adult molars)*
- Stainless Steel Crowns *(caps)*
- Dental Referrals *(as needed)*
- Pulpotomy *(removing tooth nerve)*



INTEGRATED, AFFORDABLE & QUALITY DENTAL CARE COMING TO YOU

Covenant Community Care's state licensed dentists and/or hygienists will provide the following dental services as needed: exam, cleaning, x-rays, fluoride treatment and sealants. At select sites, additional care such as extractions and fillings may be done. To qualify for our free services provided by our mobile program, your household income must fall below the amount listed for your family size on the Income Based Eligibility chart. For those patients who have dental insurance, services will be billed for reimbursement. Patients requiring further dental care will be referred to one of our 2 full-service Family Dental Centers. Uninsured patients may qualify for a discount based on a sliding fee scale at the Family Dental Center.

WOULD YOU LIKE YOUR CHILD TO RECEIVE SERVICES AT THE MOBILE DENTAL CLINIC?

☐ YES ☐ NO

PATIENT INFORMATION

Name: | Birth Date: | Sex: ☐ Male ☐ Female | SSN:

Address: | City: | State: | Zip:

School/Site: | Teacher: | Grade:

Parent/Guardian Name (if minor): | Phone Number:

Email: | Alt. Number:

HEALTH INFORMATION

PLEASE CHECK ALL BOXES THAT APPLY:

☐ Heart Issues ☐ Asthma ☐ Seizures ☐ Bleeding Disorder ☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Communicable Diseases

☐ Surgery ☐ Immune Disorders ☐ Artificial Joints ☐ Pregnancy ☐ Mental Disorder ☐ Other:

List current medications or any dental concerns:

List any allergies:

INSURANCE INFORMATION

Patient is Insured: ☐ Yes ☐ No | Insurance Plan: | Group #: | Policy #:

Patient's Relationship: ☐ Self ☐ Child | Medicaid #: | Name of Insured: | Birth Date:

TURN OVER

PATIENT DEMOGRAPHICS

*Please check the boxes that describe your status. Covenant Community Care Family Dental Center is a non-profit public health facility. The information below is vital for future funding for this clinic. Thank you for taking your time to complete this important information. *Gender Identity and Sexual Orientation questions are optional.*

Race: ☐ African American ☐ Caucasian (White) ☐ Asian ☐ Hawaiian ☐ American Indian/ Alaska Native ☐ Pacific Islander ☐ More than one race ☐ Other ☐ Refuse to Report

Native Language: ☐ English ☐ Spanish ☐ Arabic ☐ Refuse to Report ☐ Other:

Ethnicity: ☐ Hispanic/ Latina(o) ☐ Arab/Chaldean Descent ☐ Other ☐ Refuse to Report

Migrant Worker? ☐ Yes ☐ No ☐ Refuse to Report

Seasonal Worker? ☐ Yes ☐ No ☐ Refuse to Report

Gender Identity* *(If other than sex at birth)* ☐ Transgender Male - Female to Male ☐ Transgender Female - Male to Female ☐ Other ☐ Refuse to Report

Sexual Orientation* ☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Something Else ☐ Don't know ☐ Refuse to Report

Living/Housing Situation? ☐ Transitional/Temporary Housing ☐ Outdoors (street/squatting) ☐ Staying at my own house/apartment ☐ Refuse to Report ☐ Hotel ☐ Living in Shelter ☐ Other ☐ Vehicle ☐ Unknown ☐ Living w/family, friends or others

Family/Household Size: *(Number of people living in your household)*

Family/Household Annual Income:

☐ $0-$5,000 ☐ $5,001-$10,000 ☐ $10,001-$15,000 ☐ $15,001-$20,000 ☐ $20,001-$25,000
☐ $25,001-$30,000 ☐ $30,001-$35,000 ☐ $35,001-$40,000 ☐ $40,001-$45,000 ☐ $45,001-$50,000
☐ $50,001-$55,000 ☐ $55,001-$60,000 ☐ $60,001-$65,000 ☐ $65,001-$70,000 ☐ $70,001-$100,000
☐ $100,000 or more ☐ Refuse to Report

Permission for dental services: I authorize Covenant Community Care's affiliated dentists and/or dental hygienists to provide the following dental services as needed: exam, cleaning, x-rays, fluoride, sealants, and possible additional care such as fillings and extractions. I authorize appropriate lab work to be drawn should a health provider be exposed to a health risk. I acknowledge the receipt of Covenant's notice of privacy practices. I grant the authority to Covenant Community Care, Inc. the right to take photographs/videos and to copyright, use and publish the same in print and/or electronically with or without your name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising or Web content. By signing this form I am declaring that my household income is below the amount listed for my family size, and agree to allow Covenant Community Care to bill my insurance for reimbursement. I understand that if duplicate services are received during follow up care by another provider, insurance benefits may be affected. I release Detroit Public Schools Community District from any and all claims, losses, damages, injuries, and liabilities and waive all rights in connection with my participation in the "Covenant Community Care Mobile Dental Program." I hereby agree to indemnify and hold harmless the Detroit Public Schools Community District and its respective board members, officers, directors, agents, employees or volunteers from any claims, causes of action, lawsuits or other judicial proceedings, costs, expenses, damages and liabilities, including attorneys' fees, arising from or related to attendance and, participation in the "Covenant Community Care Mobile Dental Program."

INCOME BASED ELIGIBILITY

Family Size	Income
1	$24,121 *or over*
2	$32,481 *or over*
3	$40,841 *or over*
4	$49,201 *or over*
5	$57,561 *or over*
6	$65,921 *or over*
7	$74,281 *or over*
8	$82,641 *or over*
9 *or more*	Add $4,180 *for each additional person*

SIGN AND DATE HERE

Print Name: _____ Signature: _____

I am the: ☐ Parent/Guardian ☐ Patient Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION: We are required to provide this Notice of Privacy Practices to you by the privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA".) You may request a copy of our Notice at any time. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all the records of your care generated by this office whether made by your healthcare provider or one of the office's employees. This office is required by law to: 1. Make sure that health information that identifies you is kept private; 2. Give you this Notice of our legal duties and privacy practices with respect to health information about you; and 3. Follow the terms of the Notice that is currently in effect. **How this Office May Use and Disclose Your Health information:** For Treatment, For Payment, For Healthcare Operations, Appointment Reminders, Treatment Alternatives, Health-Related Benefits and Services, Research, As Required By Law, To Avert a Serious Threat to Health or Safety, Health Oversight Activities, Lawsuits and Disputes, Law Enforcement, and Coroners and Medical Examiners. **You have the following rights regarding the health information this office maintains about you:** Right to Inspect and Copy, Right to Amend, Right to an Accounting of Disclosures, Right to Request Restrictions, Right to Request Confidential Communications Right to a Paper Copy of This Notice. You may also obtain a copy of this Notice at our website. www.covenantcommunitycare.org. We reserve the right to revise this Notice. Any revised Notice will be effective for health information we already have about you as well as any information we receive in the future. We will post a copy of any revised Notice in this office. Complaints: If you believe your privacy rights have been violated, please contact our Compliance Officer at 313-228-0220. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT. Other uses and disclosures of your health information not covered by this Notice of Privacy Practices will be made only with your written authorization.Omnibus Final Rule Update: Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the Health Information technology for Economic and Clinical Health (HITECH) Act, are as follows: You have the right to be notified of a data breach. You have the right to ask for a copy of your electronic medical record in an electronic form. You have the right to opt out of fundraising communications from Covenant Community Care, and Covenant Community Care cannot sell your health information without your permission. Certain uses of your medical data, such as use of patient information in marketing, require prior disclosure and your authorization. Use and Disclosure of any psychotherapy notes require your authorization. Other uses and disclosures not described in this notice will be made only with your authorization. If you pay in cash in full (out of pocket) for your treatment, you can instruct Covenant Community Care not to share information about your treatment with your health plan. Compliance Officer and Medical Records Administrator: Jan Pillai email: jpillai@covenantcommunitycare.org. Full notice of privacy practice is posted on our website at www.covenantcommunitycare.org