



Dear Parent(s) or Guardian(s):

This year your child has an opportunity to once again participate in the **Caring for Kids** school-based cavity prevention program through Community Health Connections Family Health Centers.

Who is Caring for Kids? The only program providing on-site dental screenings, cleanings, fluoride varnishes, dental sealants and education to every child regardless of insurance status or ability to pay. Services are provided by local Community Health Connections dental professionals with over 30 years of experience.

Who is Eligible to Participate? Every school-aged child regardless of insurance status or ability to pay.

Any child that is a Mass Health member

Any child that has dental insurance yet has circumstances preventing access to dental care

Any child that does not have dental insurance

Any child that does not have a regular dental provider

Is this a new program? No, we have been operating since 2002 in all elementary schools within the school districts of Fitchburg, Leominster, Gardner, Winchendon, Templeton & Phillipston.

What is the cost? The Caring for Kids dental program is Free. **There is no direct cost to the patient, however if the child has insurance the insurance will be billed.**

Purpose:

The Caring for Kids cavity prevention program will provide the following services in your child's school:

- 1. A dental examination:** To check the teeth, mouth, and gums (2 times in the school year).
- 2. Teeth cleaning:** To remove plaque (up to 2 times in the school year).
- 3. Fluoride treatment:** Painted on the teeth to protect them from cavities (up to 4 times in the school year).
- 4. Sealants:** Placed on the chewing surface of the teeth to prevent cavities (2 times in the school year).
- 5. Health education:** "To teach children how to care for their teeth (2 times in the school year).

If your child needs a dentist, we will help you find a local dentist and get an appointment for care.

Preventive Care:

The care provided by Caring for Kids is to prevent cavities and does not replace regular dentist care.

Child's First Name

Child's LastName

Teacher

Grade

YES I give permission for my child to participate in the **Dental Program**. I understand that my child will receive a dental screening (2 times in the school year), fluoride varnish (up to 4 times in the school year), dental cleaning (up to 2 times in the school year) and dental sealants (2 times in the school year) as part of the program. I authorize the Caring for Kids staff to release information regarding treatment for purposes of billing my insurance. [PLEASE COMPLETE REST OF FORM]

NO I do **NOT** wish for my child to participate in the Dental Program.

Questions:

If you want any further information about this program or have any questions please contact Heather Reid, Program Director at 978-413-6977. **Agreement:**

I read and understood this Consent Form. I was given the chance to ask questions about this program. My questions were answered. I agree to allow my child to participate in this program. I understand there is no cost to me for any care my child receives, however my insurance may be billed.

Signature: _____ Date ■

Notice of Information Practices
Effective: April 14, 2003

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review this carefully. CHC Family Health Center is a federally funded 330 community health center. This notice applies to the Health Center and physicians as described in this brochure.

Patient Privacy

At CHC Family Health Center, your privacy is a priority. We follow strict federal and state guidelines to maintain the confidentiality of Your medical (protected health) information.

Protected Health Information

Protected health information (PHI) is any information about your past, present or future health care, or payment for that care that could be used to identify you. Members of our workforce and our business associates may only access the minimum amount of protected health information that they need to complete their assigned tasks.

Use and Disclosure of PHI

When you visit CHC Family Health, we use and disclose your protected health information to treat you, to obtain payment for services and to conduct normal business known as health care operations. We may also share information with a contracted business associate who must meet our privacy requirements. Examples of how we use and disclose your information include:
Treatment-We document each visit and/or visit. This documentation may include your test results, diagnoses and medications or other therapies. This allows your doctors, nurses and other clinical staff to provide the best care to meet your needs. **Payment** We document the service and supplies you receive at each visit so that you, your insurance company or another third party can pay us. We may tell your health plan about upcoming treatment or services that require its prior approval. **Health Care Operations** Medical information is used to improve the services we provide, to train staff and students, and for business management, performance improvement and customer service. We may also use information to:

- Recommend treatment alternatives
- Tell you about health benefits and services
- Communicate with other Health Center providers or business associate for treatment, payment or health care operations
- Send or make appointment reminders
- Communicate with family or friends involved in your care with your permission

Contact you about support for the Health Center (fundraising)* *Services followed by an asterisk (*) are optional. Tell the reception clerk or fundraiser (if contacted) that you do not wish to participate.* There are limited times when we are permitted or required to disclose medical information without your signed permission. These situations include the following: For public-neattli activities such as tracking diseases or medical devices, to protect victims of abuse or neglect, for federal and state health oversight, activities such as fraud investigations, for judicial or administrative proceedings, if required by law or for law enforcement, to coroners, medical examiners and funeral directors, for organ donation, To avert serious threat to public health or safety for specialized government functions such as national security and intelligence, to workers' compensation if you are injured at work, to a correctional institution if you are an inmate, for research following strict review to ensure protection of information. Other uses and disclosures not previously described may only be done with your signed authorization. You may revoke your authorization, in writing, at any time. **Our Responsibilities**

CHC Family Health Center is required by law to maintain the privacy of your medical information, provide this notice of our duties and privacy practices, and abide by the terms of the notice currently in effect. We reserve the right to change privacy practices and make the new practices effective for all the information we maintain. Revised notices will be available from your health care provider. **Your**

Rights

You have the right to: Request that we restrict how we use or disclose your medical information (we are not required to abide by your request), Request that we use a specific, telephone number or address to communicate with you, inspect and copy your medical information (fees will apply)* Request amendment to your medical information (reason required)*, receive an accounting of how your, medical information was disclosed (excludes disclosures for treatment, payment, health care operations and some required disclosures: fr as may apply)\obtain a paper copy of this notice even if you receive it electronically, register a complaint-see back of brochure, request to be removed from our inpatient list * Request must be in writing

To Contact Us

If you have questions about this notice, contact the privacy officer or visit: www.chcfhc.org.

If you would like to exercise your rights or if you feel your privacy rights have been violated, contact the privacy officer: CHC Family Health Center Privacy Office 275 Nichols Road Fitchburg, MA 01420 Tel: 978-878-8100 All complaints will be investigated and you will not suffer retaliation for filing a complaint. You may also file a complaint with the secretary of health and human services in Washington, DC.

I **hereby** acknowledge that I have received a copy of CHC Family Health Centers' **Notice** of Information Practices.

I understand that the Notice of Information **Practices describes how CHC Family Health Centers use** and disclose my medical and billing information. **The** Notice of Information Practices also describes how CHC Family Health Centers describes my rights and how I can receive additional information.

SIGNATURE OF PARENT/LEGAL REPRESENTATIVE

DATE

RELATIONSHIP TO PATIENT



INFORMED CONSENT Title: Caring for kids School-based Oral Health

Program through Community Health Connections Family Health Centers

Invitation:

We ask that your child be part of a dental health program. The program provides dental exams and care to prevent cavities. All students from grades Pre-K through 12 may sign up to be in this program. The Caring for kids program will run for the current school year. Dentists, dental hygienists, and dental assistants will be at you child's school to provide preventive care.

Purpose:

This program will:

1. Provide children with care and education to prevent cavities
2. Improve oral health
3. Provide you with information about your child's oral health
4. Help you find a dentist in your community, if you do not already have a dentist or if you need a dentist

Treatments:

If you agree to have your child be a part of this program, the **Caring for kids** clinicians will:

Treatments for your child		Benefits	
Comprehensive prevention		Children in this program have better dental health	
Do a medical history Do dental examination or a hygiene assessment Give free toothbrush and toothpaste Teach your child how to brush Clean your child's teeth Apply fluoride to your child's teeth Seal your child's teeth Give you a report about your child's oral health Help you find a community dentist for your child's follow-up dental care		We learn about your child's overall health We learn about your child's dental needs Brushing prevents cavities Brushing prevents cavities Cleaning removes bacteria that causes cavities Fluoride hardens teeth and prevents cavities http://www.astdd.org/docs/Sept2007/FINALFivamishpaper.pdf (Sealing prevents cavities http://www.ada.org/public/topics/sealants.asp You will know what we have done and what your dentist should know about the care your child received If your child does not have a dentist we will help you find a dentist in your community for your child's dental needs	
What we do	What could happen	What we do to make sure there is no problem	What we do if this is a problem
Apply a Fluoride Varnish to your child's teeth	Extremely rare: shortness of breath, or nausea, or gum tissue swelling after application of large amount of varnish.	Apply small amounts of varnish: the size of a 1/2 pea. The varnish is packed so that it is the right amount for one child.	Follow school emergency response protocol.
Put Sealants on your child's teeth	Extremely rare: The material may irritate the gums if it touches them.	Follow directions to apply sealant correctly and do not let the material touch the gums.	Rinse the mouth with a lot of water. Follow school emergency response protocol.

Your responsibilities:

The care provided in this program is only preventive. Preventive care is not meant to replace dental care. If your child needs dental treatment, this will be your responsibility. We will help you find a local dentist to get an appointment if you need help getting dental care for your child.

Parent/Guardian Initials

Caring for Kids Health History

Child's Informatidn (Please print):

Child's Name: (first) (last) M O F O Date of birth: . / . / . School: Grade: Room: Teacher:

Child's social security number: " - " . Child's primary language: -----

Parent's name: Parent's primary language:

Parent's address: City: State: ZIP:

Parent's telephone: / ~ Email:

Dental Information:

1 - Date of last dental check-up: - / / 2. My child's only dentist is Caring for Kids. YES O NO

- 3. My child has a local dentist. YES O NO O | do not wish to answer O Dentist name: ^
4. I would like help finding a local dentist. YES O NOO
5. My child needs to take antibiotics before having dental treatment. YES O NO O Why?:
6. Please tell us about your child's dental experiences.

Medical Information:

- 1. My child has had serious health problems. YES O NO O
2. My child is under a doctor's care now. YES O NO O For:
3. My child has now or had before: Anemia O Asthma O Convulsions O Diabetes O Epilepsy O Seizures O Glaucoma O Hepatitis O Heart Murmur O Heart Problems O Kidney/Liver O Rheumatic Fever O Immune Disorder HIV/AIDS O Tuberculosis O Other O

Please explain: _____

- 4. My child is taking medicine. YES O NO O Name of medicine:
5. My child is allergic to: Penicillin O Antibiotics O Aspirin O Latex O Foods O Other O

Other Information:

Child's race: Black/African American O White O Asian O American Indian/Alaskan Native O Native Hawaiian/Pacific Islander O More than one race O I do not wish to answer O

Child's Ethnic Origin: Hispanic origin: YES O NO O I do not wish to answer O

Housing: Own O Rent O Transitional (e.g.: YMCA, Hotel, Shelter) O I do not wish to answer O

Privacy: I understand that, if necessary, results of the dental examination and care provided may be shared with the school health office and/or my dental insurance provider to verify services that were provided, or as required by law or as I permit in writing.

Insurance Information:

My child has the following dental insurance that you may bill: MassHealth O MassHealth RID Number:

Delta O BC/BS O Other O Other Insurance Company Name: «

Individual Policy #: Group Policy #: _____

Subscriber Information:

Subscriber Name: Subscriber ID: Employer Name: _____

Subscriber D.O.B.: / / Subscriber S.S.N.: - -

Caring for Kids is a non-profit organization. The services we provide (exam, cleaning, fluoride, sealants, temporary restorations, toothbrush, toothpaste, and education) are equal to more than \$150 per child. No payment is required from you for this program; however, we would like permission to bill for services. This may impact your regularly scheduled appointments.

I agree that the above health information is correct. I give permission for you to bill my insurance.

Must Be Signed for Treatment

& SIGN HERE Parent/Guardian: Date: _____

Questions? Heather Reid RDH Program Director; phone 978-413-6977.

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