Sarah Luetke, RDH
P.O. Box 46 Keyport, WA 98345
P / 206-745-3808 F / 206-745-3811

Dear Patient and Family,

Thank you for your request to learn more about Sound Dental Care - Dental Hygiene Services. Enclosed are **four** forms that you will need to fill out and return to me by fax or mail. Once all forms are received we will call to schedule. You will be filling out the:

1. **Health/Dental History** form
2. **HIPPA** form
3. **Authorization/Payment** form
4. **Request for Consultation** (to be filled out by MD, PA or ARNP)

If your family member has Medicaid or Medicare, some dental hygiene services may be covered benefits. Sound Dental Care is a Medicaid provider, meaning we bill Medicaid directly for those services that Medicaid covers. Sound Dental Care does not bill private insurance.

Our first visit will ideally include initial evaluation, head and neck cancer screening, initial cleaning and fluoride. We recommend a fluoride application after the cleaning to protect the teeth against tooth decay. Our house/facility call is included. After care, we send a report and invoice to you explaining our findings and recommendation. The facility will also receive a copy of the report to keep in the resident's medical record chart.

If you have any questions after reading the information in the packet, please give us a call. Thank you again for inquiring about our services. We look forward to caring for your loved one.

Yours truly,

Sarah Luetke, RDH

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MEDICAL AND DENTAL INFORMATION

Patient's Name:		Birthdate:	Sex: M F
Facility:			
Address:	City:	State: Zip Code:	Phone: Area Code + Number: [ ]
Guardian/Parent Name:			Home Phone: [ ]
Address:			Business Phone: [ ]

*****EMAIL: ____***** **I would like to pay online: Y/N**

1. ***Is patient in good health?*** Yes _____ No _____
2. ***Is patient currently under treatment by a physician?*** Yes _____ No _____
   If yes, please explain: ____
   Name of Physician: ____________________________________ Telephone: ________________________
3. ***Has patient had a serious illness or operation within the past five years?***
   If yes, please explain: ____
4. ***Does patient have or had any of the following medical conditions?*** Check please.
   _____ Allergies to Medications _____ Asthma/lung problems _____ Diabetes
   _____ Heart Murmurs/Problems _____ Hepatitis _____ High Blood Pressure
   _____ Hip/Joint Replacement _____ HIV _____ Kidney/Liver Disease
   _____ Neurological Disorders _____ Rheumatic Fever _____ Tuberculosis
   _____ Prolonged Bleeding _____ Other: (Please explain)
   ____
   ____
5. ***Has patient required a blood transfusion?*** **Yes** _____ **No** _____
6. ***Has the patient experienced bleeding that would not stop?*** **Yes** _____ **No** _____
7. ***Is the patient taking any medications?*** **Yes** _____ **No** _____

If yes: **NAME OF MEDICATION(S)** **DOSAGE** **PURPOSE**
Attach Medication List
____
____
____

Motor Skills: _____ Poor _____ Fair _____ Good ***Speech:*** _____ Poor _____Fair _____ Good
Vision: _____ Poor _____ Fair _____ Good ***Hearing:*** _____ Poor _____ Fair _____ Good

To which dentist shall I send information?________________________________ Telephone: ______________________
Date when last seen? __________________________
Which services were received? Exam? ______ Cleaning? _____ Fillings? _____ Emergency? _____

Has it been difficult to receive dental care? Yes _____ No _____
Please explain: ____

Social Security Number ______________________ ***ProviderOne/Medicaid?*** (attach copy of card) Yes_____ No _____
Dental Insurance? Yes _____ No _____ (Please provide information on Authorization for Dental Hygiene Services form)

I certify that the above information is complete and true to the best of my knowledge. I authorize services provided by Sound Dental Care. I give permission to *Sound Dental Care* to bill for treatment using a ProviderOne (Medicaid) number, other insurance provider number, or I will pay privately.

____ _________________________________
Signature of Patient/Parent/Guardian **Date**

For Questions Call/Fax: Sarah Luetke, RDH P / 206-745-3808 F / 206-745-3811

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NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES (HIPPA)

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.

Sound Dental Care (SDC) is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. SDC will not use or disclose your health information except as described in this Notice. This Notice applies to all of the dental and medical records generated by SDC, as well as records we receive from other providers.

USES AND DISCLOSURES REQUIRING YOUR CONSENT: With your consent, SDC may use and disclose your health information for the following purposes.

TREATMENT: SDC may use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your dental or medical record information to your attending dentist and other health care providers who have a legitimate need for such information in your care and treatment. Different departments may share health information about you in order to coordinate specific services, such as prescriptions, lab work and x-rays. We may use or disclose your health information for appointment reminders or other supportive services.

PAYMENT: SDC may release health information about you for the purposes of determining coverage, billing, claims management, medical data processing, and reimbursement. The information may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill, and may include copies or excerpts of your dental record which are necessary for payment of your account. For example, a bill sent to a third party payer may include information that identifies you, your diagnosis, and the procedures and supplies used. We may also provide payment information to other care providers who have been involved in your care, e.g., a dentist of record.

ROUTINE HEALTHCARE OPERATIONS: SDC may use and disclose your health information during routine healthcare operations, including quality assurance, utilization review, dental/medical review, internal auditing, accreditation, certification, licensing or credentialing activities of SDC, dental/medical research and educational purposes. SDC may engage outside companies to carry out certain aspects of routine healthcare operations. These entities are called the "business associates" of SDC. SDC may need to disclose your health information to the business associates to allow them to perform their duties. The business associates will, in turn, use and disclose your health information as they conduct business on SDC's behalf. Examples of business associates, include, but are not limited to consultants, accountants, lawyers, billing agents, medical transcriptionists and third-party billing companies. SDC requires the business associate to protect the confidentiality of your health information.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION: SDC may not disclose your health information to persons outside of EDHS for purposes other than treatment, payment or healthcare operations without your authorization. In addition, SDC may not use or disclose psychotherapy notes written by your mental health provider, if any, without your authorization, even for treatment, payment or healthcare operations. You have the right to revoke any authorization you have previously given by submitting a written statement of revocation to SDC.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT:

FAMILY/FRIENDS: SDC may disclose your health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you have any objection to the use and disclosure of your health information in this manner, please tell us.

USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT CONSENT OR AUTHORIZATION

RESEARCH: Under certain circumstances, SDC may use and disclose your health information to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

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REGULATORY AGENCIES: SDC may disclose your health information to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment, the Joint Commission on Accreditation of Healthcare Organizations or the Board of Dental Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

LAW ENFORCEMENT/LITIGATION: SDC may disclose your health information for law enforcement purposes as required by law or in response to a court order.

PUBLIC HEALTH: As required by law, SDC may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, the SDC is required to report the existence of a communicable disease, such as acquired immune deficiency syndrome ("AIDS"), to the Department of Public Health and Environment to protect the health and well-being of the general public.

WORKERS' COMPENSATION: SDC may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

MILITARY/VETERANS: SDC may disclose your health information as required by military command authorities, if you are a member of the armed forces.

AS OTHERWISE REQUIRED BY LAW: SDC will disclose your health information in any situation where such disclosure is required by law (e.g., child abuse, domestic abuse).

YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION: Although all records concerning your treatment obtained at SDC are the property of SDC, you have the following rights concerning your health information:

RIGHT TO CONFIDENTIAL COMMUNICATIONS: You have the right to receive confidential communications of your health information by alternative means or at alternative locations. For example, you may request that the SDC only contact you at work or by mail.

RIGHT TO INSPECT AND COPY: You generally have the right to inspect and copy your health information, except as restricted by your provider or by law.

RIGHT TO AMEND: You have the right to request an amendment or correction to your health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your dental record.

RIGHT TO AN ACCOUNTING: You have the right to obtain a statement of the disclosures that have been made of your health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on certain uses and disclosures of your health information. If we are able to agree to your request, we will abide by the restrictions.

RIGHT TO RECEIVE COPY OF THIS NOTICE: You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.

RIGHT TO REVOKE CONSENT OR AUTHORIZATION: You have the right to revoke your consent or authorization to use or disclose your health information, except to the extent that action has already been taken in reliance on your consent or authorization.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS: If you have questions or would like more information regarding any of the rights listed above, please contact SDC.

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED: You may file a complaint with the SDC or with the Secretary of the Department of Health and Human Services. To file a complaint with SDC, please contact: Sarah Luetke, RDH at (206)745-3808. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

CHANGES TO THIS NOTICE: SDC will abide by the terms of the Notice currently in effect. SDC reserves the right to change the terms of this Notice at any time. Any new notice provisions will be effective for all protected health information that it maintains. SDC will mail any revised Notice to the address indicated on the Consent to Treat Agreement, Patient Information Forms or such other address you may provide to us from time to time.

Signature of client or DPOA____ **Date** ________________

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P.O. Box 46 Poulsbo, WA 98345
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AUTHORIZATION FOR DENTAL HYGIENE SERVICES

I hereby request and authorize that ____
Print client/resident's name
receive dental hygiene services. This treatment is not a comprehensive oral health care service, but is provided as a preventive service only. The patient should be examined by a licensed dentist for comprehensive oral health care services annually. The first dental hygiene service appointment will include initial evaluations, routine or difficult prophylaxis, or quadrant periodontal debridement as indicated by the oral conditions, denture/partial cleaning, and fluoride application as needed, unless advance directives are given to Sound Dental Care (SDC).

____ Please check here for Private Client/Resident: I agree that fees for services will be paid, upon receipt of statement, to SDC by the responsible party indicated below.

____ Please check here for Client/Resident with Private Dental Insurance: I agree that fees for services will be paid, upon receipt of statement, to SDC by the responsible party indicated below.
I have contacted my insurance company to determine:

- if the policy will pay for services directly provided by a dental hygienist
- which services my policy will pay for
- if prior authorization is needed by the insurance company for dental hygiene services

I have obtained forms that I can submit to my insurance company for reimbursement. I will send one of these insurance forms to SDC to keep on file for provider information that will assist the responsible party with insurance form submitting. This form will be returned by SDC with the invoice statement to the responsible party, to then be completed, signed and mailed by the responsible party to the insurance company for reimbursement.

_____ Please check here for Medicaid Client/Resident:
I understand that Medicaid currently covers two dental cleanings per year and that SDC may be recommending services beyond those covered by Medicaid. I can choose to agree to those in advance by written prior Authorization to SDC, on the behalf of the client/resident.
I agree to pay privately for those services that Medicaid and/or the residential facility will not pay for.

If the client/resident has both Medicaid and private dental insurance, private insurance is the primary payer for service per Medicaid regulation. I will send SDC a copy of the private insurance reimbursement statement sent to me, so that SDC can then bill Medicaid for the services that private insurance did not pay for. (Please list all private and Medicaid insurance information on the back of this form.)

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I have read and understand the general information for informed consent for dental hygiene services. I have read, signed and dated the Client Confidentiality form.
I accept the risks of treatment in hopes of obtaining the desired beneficial results of treatment. I understand that the results of treatment cannot be guaranteed and that I am free to withdraw my consent at any time.

Signature of responsible party:

____

Print Name: ______________________________________

Relationship to Client/Resident ______________________

Address: ______________________________________

____

Telephone: ______________________________________

Date: ______________________________________

(Please send a signed copy of this authorization to SDC)

Private Dental Insurance Information

Insurance Company Name ______________________________________

Insurance Co. Address ______________________________________

____

Insurance Co. Telephone ______________________________________

Name of Subscriber ______________________________________

ID Number of Subscriber ______________________________________

Group Number (if given) ______________________________________

Plan Number (if given) ______________________________________

ProviderOne Number (Medicaid) ______________________________
(Please enclose a legible copy of the subscriber's ProviderOne card)

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Request for Consultation

To Primary Care Provider: ______________________________________

Regarding Individual or Resident: ____________________________

Residential Facility if Indicated: _____________________________

Fax Number of Facility: ___________________________________

Date of Request: _______________________________________

The Individual, Resident, or their Guardian has requested dental hygiene treatment. The treatment will involve initial evaluations, oral infection control through removal of bacterial debris by scaling and root debridement, possible denture/partial denture cleaning, and application of topical fluorides for caries prevention, as needed. The scaling and debridement are likely to cause gingival bleeding, transient bacteriemia and concern for persons who receive anticoagulants. Topical anesthetic and oral rinses may be used. Appointments are scheduled 45 to 60 minutes in length. Follow-up appointments will be scheduled as needed with the consent of the Individual or Guardian. The Client will be referred to their dentist of record for comprehensive dental services.

Please complete the following orders by circling yes or no.

Resident may have dental hygiene services as needed. **Yes** **No**
Comment: ____

Resident requires Antibiotic pre-medication. **Yes** **No**
Rx: ____
Comment: ____
Other: ____ **Yes** **No**
Rx: ____
____
Comment: ____

____
Primary Care Provider Signature
Date __________________

PLEASE FAX COMPLETED FORM TO SOUND DENTAL CARE F / 206-745-3811 FORM WILL BE KEPT ON FILE WITH THE CLIENT'S MEDICAL RECORDS.

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INFORMED CONSENT - APPLICATION OF SILVER DIAMINE FLUORIDE

Silver Diamine Fluoride (SDF) is an antibiotic liquid medication. It is used to slow or stop decay AND treat tooth sensitivity.

Sound Dental Care would like your consent to perform the following procedure:

1) Dry the teeth
2) Place a small amount of SDF on visible cavities
3) Allow to dry (optimally one minute)
4) Apply fluoride varnish to cover

Benefits:

- SDF may slow or stop tooth decay
- SDF may help relieve sensitivity

Possible Side Effects:

- The cavity and white pre-cavities will darken permanently as the decay process stops.
- Healthy tooth structure will not discolor.
- Discolored tooth structure can be covered or replaced with a filling at a later date.
- Tooth colored fillings and crowns may also discolor if SDF is applied to them. Normally this is temporary and can be polished off.
- If SDF comes in contact with skin and/or gums, temporary discoloration may occur. It will disappear in 1-3 weeks.
- Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that the procedure will not stop the decay, and no guarantee of success is granted or implied.
- This treatment to stop or slow decay may not prevent the cavity from growing. In that case the tooth will require further treatment, such as repeat SDF, filling or crown, root canal or extraction.

Alternatives to SDF:

- No treatment, which may lead to continued deterioration of the tooth structure and cosmetic appearance. Symptoms may increase in severity.
- Other treatment may include placement of fillings, other restorations, or extraction.

Patient Name ______________________________ Date ________________

Signature of Patient or Guardian

____