MO Ozarks
MISSOURI OZARKS COMMUNITY HEALTH

SCHOOL BASED DENTAL CARE

Dear Parent/Guardian:

Missouri Ozarks Community Health will be visiting your school to provide onsite dental services through our mobile dental clinic.

The initial visit will consist of diagnostic and preventive services. These dental services include but are not limited to screenings, exam, x-rays, cleaning, fluoride and sealants. If treatment beyond preventive services is recommended, a separate consent form will be sent home to review prior to any further treatment. This can include treatment such as fillings, crowns, extractions, and space maintainers. A referral to one of our main clinic sites or for specialty care may be required.

If you currently do not have a dentist or are looking for a dental home for your child, we encourage you to sign up. We accept Medicaid/MOHealthnet and private dental insurance. We also offer a program for children without insurance, with services provided for all children regardless of the ability to pay.

If you would like your child to receive dental services, please fill out the attached patient information form and return it to school as soon as possible. Please make sure you complete all information, front and back, which includes a consent and agreement statement that must be filled out and signed by the parent/ guardian.

Sincerely,

Sybil A. Fortner, D.D.S.
Director of Mobile Dental Services

Ava (417)683-5739 504 W Broadway , Ava MO
Mansfield (417)924-8809 804 N Highway 5, Mansfield MO
Gainesville (417)679-2775 201 S Elm, Gainesville MO
Cabool (417)962-5422 904 Zimmerman, Cabool MO
Mt. Grove (417)926-1713 1604 C N Main, Mt. Grove MO
Houston (417)967-0772 1340 Sam Houston Blvd., Houston MO

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SCHOOL BASED DENTAL CARE
PATIENT INFORMATION and CONSENT FORM

Missouri Ozarks Community Health will provide dental services at your child's school during school hours. Your child's participation is voluntary. In order for them to receive dental services you will need to complete this form and return it to the school. Please contact your school nurse or Missouri Ozarks Community Health if you have any questions.
PLEASE COMPLETE USING BLUE OR BLACK INK

PATIENT INFORMATION:

Patient's Name:_____

Name patient wishes to be called:_____

Date of Birth:_____/_____/_____ **Patient's age:** _____ **Sex:** _____

Grade:_____ **Homeroom Teacher:** _____**School patient attends:**_____

Parent/Legal Guardian Name:_____

Home address (mailing):_____

City:_____ **State:** _____ **Zip:** _____

Telephone numbers: Home:_____ **Cell:**_____
Other:_____ **(Please circle best # to call during school hours)**

Preferred Pharmacy:_____

Medicaid/ MOHealthNet: YES _____ **NO** _____
ID Number: _____

Private dental insurance: YES _____ **NO** _____
Insurance Company name:_____ **Ins. Phone:**_____
Name of Insured Adult:_____ **DOB of Insured:**_____
Member/Policy #:_____ **Group #:**_____ **Employer:**_____

Is your child eligible for free/reduced school lunches? YES _____ **NO** _____

Has your child seen a dentist before? YES____ **NO**_____
Date of last dental visit:_____
If yes, treatment received: _____

Please check the reason(s) for seeking dental care for you child:

Routine checkup _____	Appearance of teeth ____	First visit _____
Swelling of face _____	Toothache _____	Crowding of teeth _____
Accident to the teeth ____	Bleeding around the teeth____	Other (specify) _____

DENTAL AND MEDICAL HISTORY OF YOUR CHILD: (Please circle YES or NO where indicated)

Has the child had any unusual or unpleasant experiences in a dental or medical office?……..	YES	NO
Has the child ever had any injuries to the face, mouth or teeth?.....	YES	NO
Has the child ever had a toothache? ……..	YES	NO
Does the child have any oral habits such as thumb sucking?.....	YES	NO
Is the child presently in good health?.....	YES	NO
Is the child presently under the care of a physician?.....	YES	NO
Has the child been in a hospital or had surgery?.....	YES	NO
Is the child's immunization record up to date?.....	YES	NO

OVER, PLEASE »

Does your child take any fluoride supplements?..... YES NO
Is the child taking any medications at this time?..... YES NO
If yes, please list:_____
Has the child had any unusual reaction or allergy to medication like
Penicillin, aspirin, or local anesthetics?..... YES NO
If yes, please list and explain: _____
Does your child have a history of seasonal allergies?..... YES NO
Does your child have a latex allergy?..... YES NO
Does your child have any allergies not listed above? _____ YES NO

Does the patient have a history of:

Abnormal bleeding……	YES	NO	Cerebral Palsy……	YES	NO
ADD/ADHD……	YES	NO	High blood pressure……	YES	NO
AIDS or HIV……	YES	NO	Kidney disease……	YES	NO
Liver disease……	YES	NO	Convulsions(seizures)/Epilepsy	YES	NO
Heart disease……	YES	NO	Autism/ASD ……	YES	NO
Fainting/Dizziness……..	YES	NO	High fevers……	YES	NO
Diabetes……	YES	NO	Tonsillitis……	YES	NO
Tuberculosis (TB)……	YES	NO	Behavioral difficulty……	YES	NO
Anemia……..	YES	NO	Hepatitis……..	YES	NO
Nutritional problem……	YES	NO	Vision problems……	YES	NO
Difficulty with speech……	YES	NO	Thyroid disease……	YES	NO
Difficulty with hearing……	YES	NO	Developmental Delay……..	YES	NO
Metal pins/rod/implants	YES	NO	Cold sore/fever blister……	YES	NO

Cancer or tumors……..YES NO -----→ *If yes, please explain* _____
Congenital Heart Defect ……....YES NO ------→*If yes, does child require premedication? YES NO*
Asthma……YES NO ------→*If yes, when was last asthma attack?*_____
Do they require an inhaler? YES NO

Any special conditions not listed above?

_____

CONSENT FOR DIAGNOSTIC AND PREVENTIVE TREATMENT AND ASSIGNMENT OF BENEFITS:

I consent for my child to receive preventive dental services in Missouri Ozark Community Health's mobile clinic. Dental preventive services include but are not limited to screenings, exam, x-rays, cleaning, fluoride and sealants. If treatment beyond preventive services is recommended, a separate consent form will be sent home to review prior to any further treatment.
I hereby give consent to the Missouri Ozarks Community Health staff to perform those procedures and treatments, which are deemed necessary with the **exception** of :

Assignment of benefits: I understand that eligible services may be billed to Medicaid and/or private insurance. I hereby instruct and direct all proceeds of insurance to be paid to Missouri Ozarks Community Health to be paid by check for the dental benefits allowable, and otherwise payable to me, under my current insurance policy as payment toward the total charges for the professional service rendered. I authorize MOCH to release or receive information on eligibility and/or benefit information for the purpose of filing insurance claims. I also understand that additional information may be needed from my file to achieve maximum benefits. I acknowledge receipt of the HIPAA Notice of Privacy Practice attached to this consent form. I understand that this consent may be revoked at any time upon my request.

This treatment consent will be in effect for the year August 1, 2025 through July 31, 2026.

Patient Name:_____

Parent/Legal Guardian Signature:_____ Date_____

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Mansfield (417)924-8809 804 N Highway 5, Mansfield MO
Gainesville (417)679-2775 201 S Elm, Gainesville MO
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PO Box 1359 | Ava, MO 65608 | 417-683-5739, Ext. 1111
www.mo-ozarks.org

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: JUNE 1, 2017

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

FOR YOUR SAFETY, PLEASE REVIEW AND BE FAMILIAR WITH THIS INFORMATION.

This notice will explain how Missouri Ozarks Community Health (MOCH) may use and disclose your medical information, our obligations related to the use and disclosure of your medical information and your rights related to any medical information that we have about you. This notice applies to the medical records that are generated in or by MOCH's Clinics, school services, mobile services, home services, MOCH entities. Please note that behavioral health records are considered part of the medical record and will be released as such.

This notice also describes the practices of MOCH and that of any service provider acting on behalf of the organization with regards to your Protected Health Information (PHI) created while you are a patient of our clinics. All providers and personnel acting on behalf of MOCH are also subject to this notice. In addition, providers and staff working collaboratively may share medical information with each other for treatment, payment, or health operations described in this notice. As required by law, we ensure that medical information that identifies you is kept private; that you have access to privacy policies regarding our legal duties, and that these policies are current.

With a few exceptions, we are required to obtain your authorization for the use or disclosure of your information. We have listed some of the reasons why we might use or disclose your medical information and some examples of the types of uses or disclosures below. Not every use or disclosure is covered. However, all of the ways that we are allowed to use and disclose information will fall into one of these categories.

If you have any questions about the contents of this Notice of Privacy Practices, or if you need to contact someone at this site about any of the information contained in this Notice of Privacy Practices, please contact: **Privacy Officer at (417) 683-5739, Ext. 1111.**

Printed on 1-5-23

PLANNED USES OR DISCLOSURES TO WHICH YOU MAY OBJECT

We will use or disclose your health information for any of the purposes described in the previous section unless you affirmatively object to or otherwise restrict a particular release. You must direct your written objections or restrictions to: Privacy Officer, PO Box 1359, Ava, MO 65608.

We may release health information about you to a friend and/or family member who is involved in your care. We can also give this information to someone who will or is helping to pay for your care.

We can disclose health information about you to a public or private entity that is authorized by law or its charter to assist in disaster relief efforts for the purpose of notification of family and/or friends of your whereabouts and condition.

OTHER USES OR DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

- Uses and disclosures of Protected Health Information for marketing purposes; and
- Disclosures that constitute a sale of your protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us written authorization to use or disclose information, you can change your mind and revoke your authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your private information. However, we will not be able to take back any disclosures that we had made prior to the date of your written notice of revocation.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the property of MOCH, you have the right to:

- **Request Restrictions:** You have the right to request that we restrict any use or disclosure of your health information. However, MOCH is not required to agree to any request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such in information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If restriction is agreed upon, we will comply with your request unless the information is needed to provide you with emergency treatment. Any request to restrict uses or disclosures must be made in writing to the Privacy Officer at MOCH. Your request must indicate: what information you want limited; whether you want to limit our use, disclosure or both; and to whom you want the limits to apply.
- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request, in writing, to the Privacy Officer at MOCH. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
- **Notice of a Breach:** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
- **An Electronic Copy of Electronic Medical Records:** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
- **Inspect and Copy your Protected Health Information (PHI):** You have the right to inspect and copy your protected health information that may be used to make decisions about your care, with the exception of psychotherapy notes. If you want to see or copy your medical information, you must submit your request in writing to MOCH's Privacy Officer. If you request copies, the state-allowed fee will be assessed for the cost associated with your request, including the cost of copies, mailing, or other supplies.

Note: In limited circumstances MOCH may deny access to your health information. If access is denied, you can request that the denial be reviewed. Another licensed health care professional chosen by MOCH will review your request and the denial. MO Ozarks Community Health will adhere to the decision of the reviewer.

- **Request Amendment to your Protected Health Information (PHI):** You have the right to request that your health information be amended (changed) if you believe that it is incorrect or incomplete. You have a right to request changes for as long as the information is retained by MOCH. To request a change in your PHI, you must submit in writing a request to MOCH's Privacy Officer which includes the reason you think the information is incorrect or incomplete and specification as to whom you want notified of the change. We must notify you within 60 days upon receipt of your written request. This period may be extended by 30 days provided we notify you of our reason for delay and the expected date of completion.

Note: MOCH may deny your request if it is not in writing and if it does not include a reason why the information should be changed. We can also deny your request for the following reasons: the information in question was not created by MOCH or the individual or outside entity is no longer available; the information is not maintained as part of your medical records at MOCH; the information is not part of the information that you

would be permitted to inspect or copy; or we have reason to believe that the information is accurate and complete.

- **Accounting of Disclosures:** You have the right to receive an accounting of disclosures of medical information that we have made, with some expectations. You must submit a written request to MOCH's Privacy Officer the specific time period of the request and how you want the information reported to you. Requests cannot be made for periods longer than six years and may not include dates prior to January 1, 2003. You have the right to receive a free accounting of disclosures every twelve months. If you request more than one accounting in a single twelve month period, the state-allowed fee will be assessed for the cost associated with your request, including the cost of copies, mailing, or other supplies. MOCH will notify you of the charge for such a request and you will have the opportunity to withdraw or change your request before any cost is incurred. Disclosures made prior to an authorization signed by you or your representatives are exempt from the accounting of disclosures policy.
- **Receive a Copy of this Notice of Privacy Practices:** Even if you have agreed to receive this notice in another form, you can still have a paper copy of this notice. To obtain a paper copy of this notice, contact the medical records department of the Privacy Officer. You can also obtain a copy of this notice at our website: www.mo-ozarks.org.

COMPLAINTS

If you believe that we have violated any of your privacy rights or have not adhered to the information contained in this Notice of Privacy Practices, you can file a complaint by putting them in writing and sending it to the Chief Operating Officer, PO Box 1359, Ava, MO 65608. You may also file a complaint with the Secretary of the US Department of Health and Human Services, 200 Independent Ave, S.W., Washington, D.C. 20201. To acquire a copy of MO Ozarks Community Health's complaint form, contact the medical records department at (417) 683-5739, Ext. 1111 or you may contact the Office for Civil Rights at 1 (800) 368-1019 or website.

According to the law, you will not be retaliated against nor intimidated for filing a complaint with any Missouri Ozarks Community Health clinic or the U.S. Department of Health and Human Services.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

MO Ozarks Community Health reserves the right to change or modify this Notice of Privacy Practices. Any changes can be made affective for any health information that we have or might obtain about you. Each time you receive services from MOCH, you will have the opportunity to review the most current copy of our Notice of Privacy Practices. The most recent version of our Notice of Privacy Practices will be posted in our clinics or can be obtained from the Privacy Officer.

Si teine alguna pregunta o quiere recibir el presente Aviso de Practicas de Privacidad en espafiol, dirfjase al Departamento de Privacidad y Seguridad de Datos al (417) 683 5739, Ext. 1111.

In addition to clinic departments, employees, physicians, dentists, and other MOCH personnel, the following persons will also follow the practices described in this Notice of Privacy Practices:

- Any health care professional who is authorized to enter information in your medical record;
- Any member of a volunteer group that we allow to help while you are within our facilities; any student, resident or intern.

USE AND DISCLOSURE OF MEDICAL INFORMATION

We can use or disclose medical information about you regarding treatment, payment for services or for health care operations. We may also disclose your protected health information (PHI) for the treatment activities of another provider, the payment activities of another provider, and certain limited health care operations of another collaborative entity.

For Treatment: To provide you with medical treatment or services, we may need to use or disclose information about you to doctors, dentists, nurses, technicians, health care students, or other personnel who are involved in your treatment. Departments within our operations may share medical information about you to coordinate your care. We may also disclose medical information about you to people who may be involved in your medical care after you leave our facilities such as home health agencies, your family, emergency personnel, or long term care facilities.

For Payment: We may use and disclose your medical information to bill and receive payment for the treatment that you receive from MOCH.

For Health Care Operations: We may use and disclose your medical information for health care operations. Medical information about you and other MOCH patients may be combined to evaluate the quality or effectiveness of our operations, to compare information to other health care organizations, or to improve our services. To protect your privacy, when combining information, we will remove any information that identifies you known as ''facially de-identified information."

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

For Research: We may share your PHI with researches with your authorization or when their research has been approved by an institutional review board (IRB) that has reviewed the research proposal and established protocols (waiver of permission) to ensure the privacy of your protected health information.

USES AND DISCLOSURES OF MEDICAL INFORMATION THAT DO NOT REQUIRE YOUR AUTHORIZATION:

We can use or disclose your medical information without authorization when there is an emergency, when we are required by law to use or disclose certain information, or when there are substantial communication barriers to obtaining authorization from you. The following circumstances may require that we use or disclose your health information without your authorization:

- When it is required by international, federal, state or local law;
- When it involved use or disclosure for public health activities such as mandated disease reporting, etc;
- When reporting information about victims of abuse, neglect, or domestic violence;
- When disclosing information for the purpose of health oversight activities such as audits, investigations, licensure or disciplinary actions or legal proceedings or actions;
- When as a result of a data breach, we may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information;
- When working with business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract;
- When disclosing information to collaborative organizations for the purposes of creating a limited data set which may include zip codes, dates of birth, or dates of service but may not contain patient identifiers such as name, address, phone number or social security number;
- When disclosing information for law enforcement purposes;
- When disclosing or using information for organ and tissue donation purposes;
- When we believe in good faith that the disclosure is necessary to avert a serious health or safety threat to you or to the public's safety;
- When disclosure is necessary to comply with Worker's Compensation laws or purposes;
- When required by law to notify a person subject to the jurisdiction of the FDA for public health purposes related to the quality, safety, or effectiveness of FDA regulated products or activities;
- When disclosure is necessary for specialized government functions;
- When required by military command authorities; when you are a prison inmate, information can be released to the correctional facility in which you reside for the following purposes: for the institution to provide you with health care, to protect the health and safety of others, or for the safety and security of the correctional facility.