9 CAREY ROAD
QUEENSBURY, NY 12804
518-764-3036
WWW.HHHN.ORG

Dear Parent/Guardian:

We are excited to be working with local schools to bring preventative dental services and dental education directly to children. If you enroll your child in the program, he/she will be seen by a NYS Licensed Dental Hygienist who will provide dental care and education that promotes healthy teeth and gums. Services include screening, cleaning, fluoride, sealants, education and referral for additional treatment if necessary. Upon completion of care, each child will receive an Oral Health Report Form indicating services provided.

All are welcome! If your child currently sees a dentist, he/she is still welcome to participate. We ask that you provide the information about your current dental provider on the consent form where indicated. Services will not be duplicated.

Families are not charged for services, only insurance companies if applicable. If you have dental insurance, we ask that you provide the insurance information to us. If your child does not have dental insurance, all services will be provided at **no cost**.

Instructions:
To participate, please complete the front and back of the enclosed form and return to your child's school. If your child will NOT be participating in the program, please indicate this and return the form to their school.

Dental Emergencies:
If your child has a dental emergency at any time of the day or night, call the office of his/her regular dentist if applicable. If your child does not have a regular dentist, call the Hudson Headwaters Dental Services Center at 518-623-3918.

The Healthy Smiles program is compliant with Infection Control guidelines set by the CDC, OSAP and NYSDOH. Changes in response to Covid-19 can be found at
https://www.hhhn.org/services/dentistry/school based/

To learn more about this program visit us online at www.hhhn.org or contact:

Piperlea Chico, RDH- (518) 764-3036
School Based Dental Program Director,
Dental Hygienist

School Based Dental Program Dental Hygienist- **(518) 764-8034**

Dental FAQs and Tips:

What are sealants?

- Sealants are a thin plastic coating painted onto the chewing surfaces of permanent teeth. They provide protection for your child's teeth by acting as a barrier to prevent cavities from damaging the teeth. Sealants can be applied by the Dental Hygienist.

What is Fluoride?

- Fluoride is a naturally occurring mineral. It is present in drinking water at varying levels.
- Fluoride varnish is different. It is painted on the teeth. It is quick and easy to apply and **does not** have a bad taste.

Brushing Tips

- Your child should always use a soft-bristled toothbrush.
- Toothbrushes should be replaced every **three** months.
- **Never** share a toothbrush. This can spread germs.

Flossing Tips

- Flossing cleans between the teeth where a toothbrush can't reach.
- Your child can begin flossing when any two teeth touch.

Hudson Headwaters Healthy Smiles Consent Form

☐ **Yes, I give permission for my child to be enrolled in the school based dental program.**
Fill out the form in its entirety and return to your child's school.

☐ **No, I do not give permission for my child to be enrolled in the school based dental program.**
Fill in your child's name, school name, sign on reverse, and return to your child's school.

1. Demographic Information

Child's First and Last Name | Date of Birth | Sex

Race (check one):

__White __ American Indian or Alaskan Native __Black or African American __Hispanic or Latino
__Asian or Native Hawaiian/other Pacific Islander __Multiracial __Other:

Name of School | Teacher | Grade

Child's Address | City, State, Zip

Parent Guardian Name (s) | Email Address

Home Phone | Cell Phone | Work Phone

2. Alternative Emergency Contact

Name | Relationship to Child

Home Phone | Cell Phone

3. Dental Coverage

___ My child has never seen a dentist.
___ My child does NOT have a regular dentist currently. Do you need help finding a dentist for your child? ___Yes ___No
___ My child has been to a dentist for a cleaning within the last 6 months.
Date of last dental visit: _____ Date of next scheduled cleaning: _____

Dentist Name | Phone | Address

4. Dental Insurance Information

☐ **Uninsured (no dental coverage)**

☐ **Medicaid Insurance**
ID# | CIN# | SEQ#

☐ **Private Dental Insurance**
ID# | Group#

Plan Name | Employer | Insurance Phone #

Policy Holder Name | DOB

FOR OFFICE USE ONLY:
REVIEWED BY:_____ DATE:_____

PLEASE COMPLETE FRONT AND BACK OF FORM AND RETURN TO SCHOOL.

5. Health Information								
AIDS/HIV	Yes	No	Asthma	Yes	No	Immune Deficiency	Yes	No
Bleeding Disorders	Yes	No	Artificial Joints	Yes	No	Diabetes	Yes	No
Fainting Spells	Yes	No	Epilepsy/Seizures	Yes	No	Vision Problems	Yes	No
Heart Disease	Yes	No	Hearing Loss	Yes	No	Kidney Disease	Yes	No
Heart Murmur	Yes	No	GI Problems	Yes	No	Tuberculosis	Yes	No
Hepatitis/Liver Disease	Yes	No	Low Blood Pressure	Yes	No	Vision Problems	Yes	No
Mental Health	Yes	No	High Blood Pressure	Yes	No	Surgery	Yes	No
Developmental Disability	Yes	No	Serious Injury	Yes	No	Hospitalization	Yes	No
Comments:								

Does your child take a fluoride supplement? (please circle)	Yes	No
Does your child take any medication on a DAILY basis? (please circle)	Yes	No

Please list daily medications: _____

_____

Does Your Child have any allergies to the following items? (please circle)	Yes	No

Latex Tree Nuts Seasonal Resins Foods Antibiotics Penicillin Other: _____

6. Consent To Participate

- I consent to my child receiving the following dental services: assessments, cleanings, fluoride, and sealants.
- I understand that this consent may stay in effect for one (1) school year while my child attends this school; however, this consent may be revoked by me or my designee at any time except to the extent that the person/ organization has already acted.
- It is the parent/guardian's responsibility to inform the dental provider and/or the school nurse of any changes in their child's medical information.
- I understand that a copy of my child's dental report may be given to the school nurse or designated site coordinator and that all information about my child will be kept confidential within the Partnering Agencies.
- If I have dental insurance, I authorize my insurance carrier to be billed for any services provided.
- I have been given a copy of the Hudson Headwaters Notice of Privacy Practices and Patient Bill of Rights.
- I understand that Hudson Headwaters Health Network may use my child's health information for treatment, payment, health care operations, and program evaluation.
- I understand that it is my responsibility to keep my child's dentist informed of services provided to my child by this program to avoid duplication of services which may result in me receiving a bill from my child's dentist.
- I understand that Hudson Headwaters Health Network may share information regarding my child's dental visit with my child's current dental provider (if one is listed on the consent).
- I have read and understand the dental program and I consent to have my child participate in the school based dental program.

Signature of Parent or Legal Guardian

Printed Name of Parent or Legal Guardian

Relationship to Child

Today's Date

FOR OFFICE USE ONLY:

REVIEWED BY:_____ DATE:_____

PLEASE COMPLETE FRONT AND BACK OF FORM AND RETURN TO SCHOOL.

For Office Use Only:
Health History Review @ 6MRC
Reviewed By:_____ Date:_____

HUDSON HEADWATERS HEALTH NETWORK

NOTICE OF PRIVACY PRACTICES

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures. We'll provide one accounting a year for free but will charge a reasonable fee for requests beyond that.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- If you feel your privacy rights have been violated, you may file a complaint to:

  HHHN Privacy Officer
  (518) 761-0300 ext. 31350
  PatientConcerns@hhhn.org

- You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints**
- You will not be penalized or retaliated against for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We use or share your health information in the following ways.

To Treat You

- We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

To Run Our Organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.

To Bill You For Services

- We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues

- We can share health information for certain situations such as: Preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you in regard to workers' compensation claims, law enforcement purposes, health oversight agencies and special government functions such as military, national security and presidential protective services.

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Participation in Accountable Care Organizations

- We can share health information about you within an Accountable Care Organization, such as Adirondacks ACO.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time in writing.
- We will not share substance abuse treatment records, HIV status or behavioral health records without your written permission.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.