The Smile Time Team is coming to school!

PIEDMONT
REGIONAL DENTAL CLINIC

Culpeper County

Farmington Elementary	**Yowell Elementary**
09/19/2014, 01/2015, 03/2015	10/07/2014, 01/2015, 04/2015
AG Richardson Elementary	**Sycamore Park Elementary**
09/22/2014, 01/2015, 03/2015	10/02/2014, 01/2015, 04/2015
Emerald Hill Elementary	**Pearl Sample Elementary**
09/24/2014, 01/2015, 03/2015	10/06/2015, 01/2015, 04/2015

FT Binns Middle and Culpeper Middle School
To be determined based upon participation – return forms to school by 09/30/2014

November -June dates are tentative based upon school schedule, participation, and weather. Confirmed dates will be assigned closer to the time and posted on PRDC's website at www.vaprdc.org

PRDC's Smile Time Team brings oral health care to you!

Services provided by the Smile Time Team:

- Comprehensive Dental Exam
- Digital x-rays
- Fluoride Varnish
- Prophy (teeth cleaning)
- Sealants (a thin, plastic material painlessly applied on the chewing surfaces of the back teeth to prevent tooth decay)
- Dental Care Goodie Bag including toothbrush, toothpaste and flosser
- Report from your child's Smile Time visit telling you exactly what care your child received and any additional needs
- Follow up call will be made from a representative of our team 72 hours after the Smile Time visit to help coordinate follow up care if needed

Return this application within 5 days of receipt with all completed information to be seen by the Smile Time Team!

♦ ♦ ♦

All children are eligible for a Smile Time Visit – See enclosed application for specifics.

PRDC is in network with all forms of Virginia Medicaid, Delta Dental, will also file other dental insurances, and offers discounted services for those who qualify.

**** Please Keep This Page For Your Records***

These materials and activity described herein, are not sponsored by the Culpeper County School Board.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/01/03 , and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter-intelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will not charge you for each page, for staff time to locate and copy your health information, and postage if you want the copies mailed to you.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Kelli Mitchell

Telephone: 540-661-0008 **Fax: 540-661-1070**

E-mail: info@vaprdc.org

Address: 13296 James Madison Highway • Orange, Virginia 22960

PIEDMONT
REGIONAL DENTAL CLINIC

PLEASE RETURN WITHIN 5 DAYS.

Print clearly in ink and completly fill out the form. Signature is required for your child to be treated.

Patient Demographics

School or Organization_____County_____

Teacher/Care Manager_____Room #_____Grade_____

Child's Legal Name_____Date of Birth_____

Male____ Female_____ Race: White _____ Black/African American _____ Asian _____ Other _____

Parent/ Gaurdian / Responsible Party Info:

Name:_____Contact Number ( ) _____

Address:_____City_____State_____Zip_____County _____

Relationship to Child_____Email_____

Is this your very first visit to a dentist? Y or N If no please provide the name of the dentist visited:_____

When was your child's last dental checkup? _____

Health & Medical Information

Please check the box that applies to the patient

Please list any medications your child is currently taking:_____

_____

Has the child had any history of, or conditions related to, any of the following:

_____None	_____Diabetes	_____Hemophilia	_____Tuberculosis
_____Asthma	_____Latex Allergy	_____ADHD	_____Heart Valve Replacement
_____Seizures	_____Heart Murmur (requiring pre-medication)	_____Hepatitus	_____Other: _____
_____Blood Disorders	_____Heart Murmur (not requiring pre-medication)	_____Kidney Problem	
_____Shunts or Artificial Joints	_____Allergies: _____	_____HIV/AIDS	

Medicaid

____ My child is covered by Virginia Medicaid/FAMIS.

12 digit Medicaid ID number: ☐☐☐☐☐☐☐☐☐☐☐☐

Dental Insurance

My child is covered by a commercial dental insurance and I would like to have their Smile Time™ visit submitted to their insurance.

Insurance Carrier: _____ Insurance Company Phone: _____

Subscriber: _____ Relationship to patient: _____

Birth date of subscriber: _____ Phone number of subscriber: _____

Employer Name: _____

Insurance ID # _____ Insurance Group #:_____

Uninsured Low Income Families

My child does not have Medicaid or dental insurance; however does receive free or reduced lunch or our family income is at 200% or below federal poverty guidelines. I understand there is a $50 discounted rate for financially qualifying. (please circle which category applies to your annual household income)

Family Size	Annual Household Income	Family Size	Annual Household Income
2	$31,460	5	$55,820
3	$39,580	6	$63,940
4	$47,700		

____ I have attached a $50 money order for the Smile Time™ visit. ____ I would like to pay by Visa/Mastercard – Please call me at _____

No Medicaid, No Dental Insurance, or Financially Overqualified for discounted visit

My child does not have Medicaid, Dental Insurance, and our family's household is 200% or above Federal Poverty Guidelines.

____ I have attached a $125 money order for the Smile Time™ visit. ____ I would like to pay by Visa/Masterard – Please call me at _____

IMPORTANT: Parent/Guardian Signature Required

Consent for Services and Care: As a custodial parent or legal guardian of the child listed above, I authorize PRDC to treat the above named patient and disclose, when requested, any and all information for any illness or injury, medical history consultation, prescriptions or treatment and copies of all medical records. I assign or authorize direct payment to the designated practiced toward any medical procedures performed and authorize PRDC to file claims on my behalf. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this authorization shall be considered effective and valid as the original. I understand that I am responsible for services not covered by my insurance plan, as well as for services rendered if I did not choose PRDC as my Primary Care Provider or if my insurance is not in effect at the time of service. I understand that PRDC renders services without regard to race, creed, color or national origin. By my signature I acknowledge that I have been informed of Virginia state law regarding blood testing: In event that a health care provider or employee is exposed to the patient's bodily fluids in a manner which may transmit disease, the patient will be deemed to have consented to testing for HIV and hepatitis and to release or disclosure of the test results to that health care provider or employee. I allow for school nurse/school representatives, and/or the dentist of my choice to obtain dental records and radiographs. I acknowledge receiving a notice of privacy practices before signing. I understand my child will receive a dental treatment plan and a contact follow up call will be made within 72 hours of the dental visit. I understand by signing this consent is valid for the entire school year. If I decide to opt out I must provide a opt out letter to PRDC, PO Box 151, Orange, VA 22960.

X SIGN HERE _____ **Date** _____

(Parent/Guardian)

Piedmont Regional Dental Clinic • 13296 James Madison Hwy • PO Box 151 • Orange, Virginia 22960
Office: 540.661.0008 • Fax: 540.661.1070 • www.vaprdc.org

Who is eligible for FAMIS?

Virginia offers several low and no cost health insurance programs for eligible children, pregnant women and adults. To find out more about each program visit www.famis.org

Famis Plus (Children's Medicaid) & Medicaid for Pregnant Women up to 143% FPL

Family Size	Yearly	Monthly
1	$16,688	$1,391
2	$22,494	$1,874
3	$28,300	$2,358
4	$34,106	$2,842
5	$39,911	$3,326
6	$45,717	$3,810
7	$51,523	$4,294
8	$57,329	$4,777
Additional person add	$5,806	$484

FAMIS (for children) – up to 200% FPL

Family Size	Yearly	Monthly
1	$23,340	$1,945
2	$31,460	$2,622
3	$39,580	$3,298
4	$47,700	$3,975
5	$55,820	$4,652
6	$63,940	$5,328
7	$72,060	$6,005
8	$80,180	$6,682

An additional 5% FPL "Standard Disregard" may be applied if a family is over the upper boundary of the income shown above for all programs: for 1 person subtract $49 from the family's gross income; for 2 $66; for 3 $82; for 4 $99; for 5 $116; for 6 $133; for 7 $150; for 8 $167; for any more subtract an additional $17 each.

If you require assistance or more information on how you can apply, please contact Kelli Mitchell, Executive Director at 540-661-0008. We are here to help!