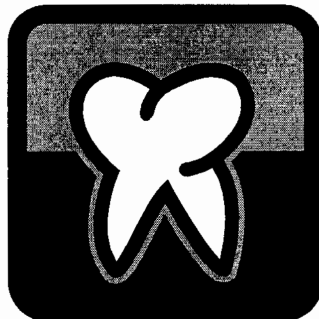
Mobile Dentist Is Coming to Celeste ISD

Celeste ISD would like to provide your child the opportunity to have dental care at school for little or no cost. Look for information to be sent home with your child in January.

The forms are due back January 30th

Please contact the school for more information at (903) 568-4530 ext. 130.



Celeste ISD Health Services

Note to Parents / Guardians:

Celeste ISD would like to provide your child the opportunity to have dental care at school. We have partnered with an in-school dental prevention program that sends Dentists out to the school to provide students with services such as dental examinations, cleanings, sealants, fluoride, fluoride varnish, radiographs, referrals to a "Dental Home", and education. This program accepts Medicaid, CHIP, and most private insurance (and will cover your child 100% of the cost). If you do not have Medicaid or dental insurance then you can pay for the dental services or you could qualify for a grant. If you are interested, please fill out the enclosed information and return it to the school by **January 30, 2009.** The Mobile Dentists will come to our school in March. Please let me know if you have any questions regarding this program, you can reach me at (903) 568-4530 ext. 130. If you would like to visit the Mobile Dentists website it is www.mobiledentists.com.

Yours in good health,

Shannon Milton, RN
School Nurse

For your newsletter ...

"Shine your Smile Day" is coming!

______________________ School is hosting Mobile Dentists/ Smile Programs on ______________.

We have invited Mobile Dentists/ Smile Programs to bring its preventive dental care program to our school because we know how important good oral health is to our children's overall general health.

"We know that tooth decay is the most common chronic and infectious disease among children," state Margo Woll, D.D.S. and Marcy Borofsky, D.D.S., co-directors of Smile Programs-Mobile Dentists. We also know poor oral health causes other problems in children, such as diminished growth in toddlers, poor nutrition due to difficulty eating and an increase in bacteria in the blood and respiratory systems."

A publication from the Centers for Disease Control states: "Children receiving dental sealants in school-based programs have 60% fewer new decayed pit and fissure surfaces in back teeth for up to 2-5 years after a single application. Among children, 90% of decay is in the pit and fissures".

Mobile Dentists/ Smile Programs will set up a mini-dental office in our building and can provide *dental examinations, cleanings, fluoride treatments, xrays and sealants (if needed)* for all children who return completed forms.

Mobile Dentists/ Smile Programs can provide these services free to families who need financial assistance *and* it has *subsidized fees* for those who chose to pay for the preventive care. <u>No child is ever turned away from Smile Mobile Dentists/ Smile Programs because of financial need.</u>

Signing up your children to see the Mobile Dental team is an easy way to get necessary preventive dental care. If you want your child to see the dentist on "Shine Your Smile Day," just fill out the permission slip and return it to your school.

You can learn more about Mobile Dentists/ Smile Programs by going to its website: www.mobiledentists.com and watching the short video about the preventive dental care program.

HELLO PARENTS!

This page is for you to keep

Smile Texas / Mobile Dentists Are Coming Soon!

Register your child now for both initial and 6-month dental check-ups

Registre su hijo para visita dental inicial y 6-meses despúes para chequeo

Fill out the permission slip today!

Our program is a highly acclaimed on-site dental care program created in compliance with the Center for Disease Control (CDC) and the U.S. Surgeon General guidelines

Our Texas dentists can provide these preventive services:

- Dental exams/screenings
- Cleanings
- Fluoride and Fluoride Varnish
- Radiographs
- Sealants *(a thin, plastic material painlessly applied on the chewing surfaces of the back teeth to prevent tooth decay)*
- All children are eligible for a screening
- Dental insurances are accepted
- Grant-assistance available
- X-rays shared with child's dentist when referral is made
- FREE toothbrushes

- We supply a dental "report card" with each visit.
- If further dental care is needed, referral to a "Dental Home" is made.
- Medicaid and CHIP cover 100% of our treatment.
- Grants provide dental preventive services for children needing financial assistance.

ENGLISH/SPANISH FORM

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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 04/14/03, 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, counterintelligence, 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 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 request access by sending us a letter to the address at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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 Officer: HIPAA Officer

Telephone: 1-888-833-8441 Fax: 1-888-330-4331

E-mail: mobiledentists@aol.com

Address: 33533 W. Twelve Mile Road, Farmington Hills, MI 48331

Tear off here – This page is for you

Smile Texas/Mobile Dentists Parent Dental Authorization Form

Please return this form to your child's teacher in the next 2 days

☺ **Signature required.** Signed consent includes **initial visit** and **6-month check-up** when appropriate.

☺ Treatment is limited to exams, cleanings, fluoride, radiographs, sealants and referral when necessary*.

General and Health Information

PLEASE PRINT CLEARLY IN INK

School or Program Name: ______________________ County: __________

Teacher: ______________________ Grade: ________ Room #: __________

Child's Legal Name: ______________________
(First) (Middle) (Last)

Child's Date of Birth: ______________________ Child's Sex: M F Last Dental Visit: __________
(Month) (Day) (Year) (Circle one)

Your child's Social Security number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Parent/Guardian Name: ______________________ Phone: ( ) __________
(signing below) (area code)

Address: ______________________ City/Zip: __________

Relationship to child: ______________________ E-MAIL: __________

Circle when child attends: M T W TH F AM / PM Full Day Head Start

✱ **IMPORTANT:** List all medications, health history & problems including allergies, heart murmur, AIDS/HIV, hepatitis, hemophilia & others below. *Attach another page if more space is needed.* **PLEASE INFORM US AT THE 6-MONTH VISIT IF THERE IS ANY CHANGE IN MEDICAL HISTORY BY FILLING OUT A NEW PERMISSION FORM**.

____

Medicaid/CHIP and Insurance Information

☺ We accept *Medicaid, CHIP* and most private insurance. They will cover your child 100%.

Child's **9**-digit Medicaid Recipient ID Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Name of dental insurance company (other than Medicaid): ______________________ Ins. Phone: __________

Group number: __________ Employer name: ______________________ Co. Phone: __________

Name of person under whom child is covered: ______________________ **BIRTH DATE of Insured Adult:** __________

Social Security number of insured adult: ______________________ Contract / ID number: __________

Secondary insurance information: Insurance Name: __________ Policy Holder: __________ Date of Birth: __________
ID Number: __________ Employer Phone: __________ Insurance Co. Phone #: __________

No Medicaid or Dental Insurance

Only Check ONE Box

☐ I am able to pay the full fee for a dental cleaning, screening & fluoride per visit.
Ages 13 or younger: **$88.00** Ages 14 or older: **$107.00**
Please make check or money order payable to **Smile Texas/Mobile Dentists, PLLC** and staple to this form.

☐ I need to pay for a subsidized service because I am unable to pay full fee. It will cover dental cleaning, screening & fluoride.
Ages 13 or younger: **$53.00** Ages 14 or older: **$71.00**
Please make check or money order payable to **Smile Texas/Mobile Dentists, PLLC** and staple to this form.

☐ Check here if you need financial aid for insurance co-pays/deductibles if any. Most insurance covers prevention 100%.

☐ Check here if you have NO dental insurance **AND** you need full financial assistance for a cleaning, screening & fluoride. We will mail you a grant application. Grants are available only once per year.

I am a custodial parent or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment described, and allow the school nurse/school representatives and/or a dentist of my choosing to obtain the child's dental record and radiographs. I authorize and direct Smile Texas/Mobile Dentists, PLLC to bill on my behalf or the child's behalf, and collect payment from any insurance or other third party payer that covers the services provided to this child. I have had an opportunity to ask any questions about treatment my child may receive. I acknowledge receiving a notice of privacy practices today before signing.*

Although you, as parent or guardian, are encouraged to attend, in the event that is not possible, you FURTHER authorize an adult school official to accompany your child during dental check-ups, screening and dental treatment at school; continue to wait for your child while the check-up, treatment, or service takes place; and see that the services are limited to no more than exams, cleanings, fluoride, radiographs and sealants. The authorized adult school official may be a school nurse, principal or administrative employee, or an adult named by one of them. All professional services will be provided by Texas licensed dentists and hygienists; managed by Smile Texas/Mobile Dentists, PLLC.

X Sign Here ______________________ Date: __________
(Parent/Guardian)

If the child has a dentist, you may wish to continue dental services with that provider. To avoid dental service or benefit duplication, please inform your dentist which services were performed at school (see oral health report card, provided after school dental visit, which will indicate services provided).

Radiographs are taken & sealants applied at dentist's discretion. In cases where additional dental care is required for restorative and/or other dental needs, the parent/guardian must follow up with a dentist of their own choosing.

Marcy Borofsky, DDS, Dental Director, Smile Texas/Mobile Dentists, PLLC, 5430 LBJ Freeway, Suite 1200, Dallas, TX 75240 OR 33533 W. Twelve Mile Road, Ste. 150, Farmington Hills, MI 48331 **Phone:1-888-833-8441, Fax:1-888-330-4331**

Visit us at: www.mobiledentists.com

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Smile Texas/Dentistas Móviles - Formulario de Autorización Dental de los Padres

Por favor, devuela esta forma al maestro de su hijo en los siguientes 2 dias

☺ **Firma requerida.** La firma de consentimiento incluye **la visita inicial** y **el chequeo (siguiente visita) en 6 meses** cuando así sea necesario.

☺ El tratamiento se limita a exámenes dentales, limpiezas, aplicación de floruro, rayos-X y selladores dentales*.

Información General de Salud

Por favor escriba con tinta y letras de molde

Nombre de la escuela o programa: ______________________ Condado: __________

Maestro: ______________________ Grado: ________ Salón #: ________

Nombre del niño: ______________________
(Nombre) (Inicial) (Apellido)

Fecha de nacimiento del niño: ____________ Género del niño: M F Fecha de última visita al dentista: __________
(Mes) (Dia) (Año)

El número de Seguro Social de su hijo: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Nombre del Padre/Guardián: ______________________ Teléfono: ( ) __________

Dirección: ______________________ Ciudad/Código Postal: __________

Relación con el niño: ______________ E-MAIL: ______________

Marque con un círculo los días que el niño asiste: L M M J V AM / PM Día entero Head Start

✱ **IMPORTANTE:** Enliste cualquier problema de salud de su hijo incluyendo medicamento, alergias, taquicardias, SIDA/VIH, Hepatitis, Hemofilia y otros.*Adjunte otra hoja si es necesario.* **POR FAVOR INFORMENOS A LA VISITA DESPUÉS DE LOS SEIS MESES SI HUBO CAMBIOS EN LA HISTORIA MEDICA LLENANDO UNA NUEVA FORMA DE PERMISO.**

____

Información de Seguro Medicaid/CHIP

☺ Aceptamos *Medicaid, CHIP* y la mayoría de seguros privados. Los servicios para sus hijos están cubiertos al 100%.

Los **9** dígitos de identificación del Medicaid del niño: ___ ___ ___ ___ ___ ___ ___ ___ ___

Nombre de la compañia de seguro dental (además de Medicaid): ______________ Teléfono: __________

Número de Grupo: __________ Nombre del empleador: ______________ Teléfono: __________

Nombre de la persona que asegura al niño: ______________ **FECHE DE NACIMiENTO del subscritor:** __________

El número de Seguro Social de la persona responsable: __________ Número del contrato/identificación: __________

Seguro secundario: Nombre del Seguro: __________ Nombre del Que Tiene el Seguro: __________ Fecha de nacimiento: __________
Número de ID: __________ Número del Trabajo: __________ Teléfono de seguro: __________

No Medicaid o Seguro Dental

Solo Cheque UN Recuadro

☐ Puedo pagar el costo entero por una limpieza, un examen, y una aplicación de fluoruro por visita. Edad - 13 años o menor: **$88.00** Edad -14 años o mayor: **$107.00.** Favor de hacer un cheque o giro postal pagado a **Smile Texas/Mobile Dentists, PLLC** y engraparlo a la forma.

☐ Necesito para pagar por un servicio subvencionado porque puedo non pagar el coste completo. Cubrirá una limpieza, un examen, y una aplicación de fluoruro por visita. Edad - 13 años o menor: **$53.00** Edad -14 años o mayor: **$71.00** Favor de hacer un cheque o giro postal pagado a **Smile Texas/Mobile Dentists, PLLC** y engraparlo a la forma.

☐ Marque aquí si Ud. Necesita ayuda financiera para el pago parcial de la compañia de seguro si existe. La mayoría de los seguros dentales cubre el 100% del costo para servicios dentales preventivos.

☐ Marque aquí si Ud. No tiene seguro dental **Y** necesita asistencia financiera completa por una limpieza, un examen y una aplicación de fluoruro. Enviaremos una aplicación de beca. Becas están disponibles sólo una vez por año.

IMPORTANTE:Padre/Guardian Se Requiere su Firma

Soy la persona en custodia o el guardian legal del menor citado anteriormente. Autorizo y consiento que el menor reciba el tratamiento dental descrito anteriormente durante este año escolar y permito a la enfermera de la escuela/representantes de la escuela y/o un dentista escogido por mi para obtener la información dental del menor y rayos-X. Autorizo a Smile Texas/Dentistas Móviles, PLLC cobrar a mi favor o del menor, y colectar pagos de cualquier compañia de seguros u otra tercera persona que cobra los gastos del servicio proveido a este menor. He tenido la oportunidad de hacer preguntas sobre el tratamiento que el menor reciba. Reconozco haber sido notificado del recibo de prácticas privadas antes de firmar.*

Aunque ustedes son los padres o tutores legales y se les ruega asistir, en caso de que no sea posible, ustedes ULTERIORMENTE autorizan a un oficial adulto de la escuela a que acompañe a su hijo(a) durante los exámenes, exploraciones y tratamientos dentales en la escuela; para esperar a su hijo/a durante el examen, tratamiento o servicio; y para asegurarse que los servicios estén limitados a no más que los exámenes, limpieza, fluoruro, radiografías y selladores. El oficial adulto de la escuela puede ser la enfermera de la escuela, el director o un empleado administrativo, o un adulto escogido por uno de ellos. Todos los servicios profesionales serán proveídos por dentistas e higienistas dentales de Texas; administrados por Smile Texas/Dentistas Móviles, PLLC.

X Firme Aquí ______________________ Fecha: __________
(Padre/Guardian)

Si su hijo tiene un dentista, quizá usted desee continuar con los servicios de éste. Para evitar servicio dental o duplicación de beneficios, por favor informe a su dentista sobre los servicios que la escuela le ha proveido (ver tarjeta de informes de salud oral, proveída después de la visita del dentista a la escuela, la cual indica los servicios proveídos).

* Radiographs are taken & sealants applied at dentist's discretion. In cases where additional dental care is required for restorative and/or other dental needs, the parent/guardian must follow up with a dentist of their own choosing.

Marcy Borofsky, DDS, Dental Director, Smile Texas/Mobile Dentists, PLLC, 5430 LBJ Freeway, Suite 1200, Dallas, TX 75240 OR 33533 W. Twelve Mile Road, Ste. 150, Farmington Hills, MI 48331 **Phone:1-888-833-8441, Fax:1-888-330-4331**

Visítenos en: www.mobiledentists.com

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