MERCYHEALTH

St. Elizabeth
Youngstown Hospital

Mobile Dental Services

Dear Parent and/or Guardian:

The St. Elizabeth Youngstown Hospital **Smile Station will** visit your school during the year to provide dental services to school-age children.

Smile Station is a mobile dental clinic equipped to provide dental care for children who *do not* have or *have never seen a dentist*.

We will see any child regardless of ability to pay. However, we do accept insurance, including Medicaid.

If you would like the dentist and staff aboard **Smile Station** to provide dental care to your child, please:

- **Complete and sign the enclosed parental consent form**
- **Include a copy of your insurance card and/or medical card with the attached parental consent**
- **You *must* include both child *and* parent social security numbers and birth date**
- **If you have private dental insurance, you are responsible for any deductible and/or co-pay**

If you do not choose to use the **Smile Station** service, we encourage you to take your child to your dentist at least twice a year.

If you have any questions about this form or **Smile Station** services, please contact our Ambulatory Services Outreach office at 330-480-3689.

Sincerely,
The Staff aboard Smile Station
St. Elizabeth Youngstown Hospital
Ambulatory Services Outreach

Please Note: Results of your child's dental examination and follow up care instructions will be given to your child to bring home.

PARENTAL CONSENT FORM

Must be completed in its entirety or we will not be able to provide care to your child

SCHOOL: _____ GRADE: _____ ROOM#: _____

If you would like to obtain dental treatment for your child at St. Elizabeth Health Center's Mobile Dental Clinic, please indicate your consent by completing this form and returning it as soon as possible. If you have any questions or would like to speak with a member of the clinical staff, please call 330-480-3689.

I give my permission for _____ (Student's Name) to be evaluated by the Mobile Dental Clinic Dentist and to receive dental services, as needed, consisting of screenings, oral examination, dental cleaning, x-rays, dental restorations (fillings,) including pulpotomies (baby root canals), crowns, fluoride treatments, extractions, local anesthesia, sealants, oral hygiene instruction, and/or emergency care as needed, provided by St. Elizabeth Health Center's Mobile Dental Clinic for as long as he/she is enrolled at school.

MEDICAL HISTORY

Does your child have any medical history of the following? (Please check all that apply)

Allergy to any medication or food? ☐ Yes ☐ No If yes, please list: _____

Taking any medication regularly? ☐ Yes ☐ No Please explain: _____

Hospitalized, or any surgery? ☐ Yes ☐ No Please explain: _____

Health problems such as: (Please check all that apply)

☐ Asthma	☐ Diabetes	☐ TB	☐ Seizures
☐ Abnormal Bleeding	☐ Cancer/Chemotherapy	☐ Hearing Impairment	☐ Sickle Cell Anemia
☐ Heart Disease	☐ Learning Disability	☐ ADD/ADHD	☐ HIV/AIDS

☐ Heart Murmur; does child need pre-medication? ☐ Yes ☐ No

If yes,what type of medication? _____

If the patient has other medical condition not listed above, please explain: _____

_____

DENTAL HISTORY

Has your child been to a dentist before? ☐ Yes ☐ No Dentist Name _____

What reason? _____

Last dental visit was?: ☐ Less than 6 Months ☐ 6 Months-I Year ☐ Longer than 1 Year

Are you planning to return to your private dentist? ☐ Yes ☐ No Does your child have a toothache now? ☐ Yes ☐ No

If yes, how long? _____ Is the child taking any medication for the toothache? ☐ Yes ☐ No

Do you or your child have any recent dental concerns? ☐ Yes ☐ No

If yes, what are your concerns? _____

Did your child receive sealants from a school program? ☐ Yes ☐ No ☐ Do not know

PERMISSION TO GATHER MEDICAL INFORMATION I also agree to allow St. Elizabeth's Mobile Dental Clinic Staff and the school nurse to exchange information as needed, including medical insurance information.

PERMISSION FOR STUDENT ESCORT Furthermore, I give permission for the Mobile Dental Staff or designated school employees to escort my child to and from the Mobile Dental Clinic.

Does your child get free or reduced price meals at school? ☐ Yes ☐ No ☐ Do not know

_____ _____

Parent/Guardian Name (print) Parent/Guardian Signature

Date: _____

CHILD REGISTRATION

Today's Date _____ School Visited _____

Patient Information

Name: _____
Last First MI

Date of Birth: _____ Social Security Number: _____

Sex: ☐ Male ☐ Female Race: ☐ Black ☐ White ☐ Hispanic ☐ Other: _____

Parent/Legal Guardian Information (if patient is a minor):

Name: _____

Relationship: _____ Telephone: (_____)_____

Address: _____

Employed: ☐ Yes ☐ No If YES: ☐ Full Time ☐ Part Time

Employer Name: _____ Telephone: (_____)_____

Employer Address: _____

Dental Insurance/Medicaid: List information for **person responsible** for Dental Insurance Coverage

Name: _____
Last First MI

Address: _____

Insurance Company:

Name: _____ Telephone: (_____)_____

Address: _____

Patient Medicaid # and/or Group/Policy #: _____

Parent/Guardian Social Security #: _____

Parent/Guardian Date of Birth: _____

Emergency Contact: nearest relative or friend

Name: _____ Relationship: _____
Last First

Telephone: (_____)_____

2CONFRM

MERCYHEALTH

CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Rev. 12/16

I. Consent to Medical Care & Treatment

This consent cannot be modified. Any handwritten changes to the form shall not be legally binding or enforceable.

1. I am seeking medical care and treatment at Mercy Health. I consent to the rendering of such medical care and treatment as is deemed necessary by my physician/practitioner and other members of the medical staff and by Mercy Health and its employees. I also understand that there are risks of injury from medical care and treatment and I acknowledge that no guarantees have been made to me about the outcome of my care and treatment.
2. I understand that my care may include examinations, diagnostic tests, medical treatment, immunization administration, taking photographs/video and making audio recordings that may be used for my care and/or by Mercy Health for quality assurance purposes and clinical documentation, as well as health care operations purposes.
3. I understand that medical, nursing and allied health students train at this facility and may be involved in my care. I also understand resident physicians may also be involved in my care. All students and resident physicians are supervised by licensed and trained physicians, and I consent to care provided by them.
4. I authorize Mercy Health to allow physicians/practitioners and other healthcare facilities who are involved in my direct care and medical services coordination to receive access to my medical record contents including my test results and reports. Access to my medical record information may be exchanged in written, electronic formats or portals.

II. Notice of Legal Relationship between Hospital & Independent Medical Practitioners

1. I understand and acknowledge that Mercy Health hospitals and facilities allows physicians/practitioners who are not employed by Mercy Health to practice at Mercy Health facilities and that these providers may render professional services to me while I am in a Mercy Health hospital or facility. I understand that these care providers may include, but are not limited to emergency department physicians, anesthesiologists, certified registered nurse anesthetists, nurse practitioners, physician assistants, radiologists, pathologist, residents, students, hospitalists and may include any attending or on-call physician or other practitioner participating or consulting in the care provided. I understand that the actions of such treating physicians/practitioners, who are not agents or employees of Mercy Health, are not directed or controlled by Mercy Health and that Mercy Health relies upon these independent contractors to use appropriate professional judgment in providing care to me. Mercy Health is not responsible for the acts or omissions of any independent contractor.
2. I understand that the hospital's charges may not include the fees of my treating physicians/practitioners, if applicable. I understand that I may receive a separate bill for these services and such bills may come directly from the physician(s), such as emergency department physicians, radiologists, pathologists, anesthesiologists, hospitalists and other specialists. I understand that the level of insurance benefits payable for treatment by my treating specialist(s) may be different from the level of insurance benefits payable for treatment provided by the hospital.

MERCYHEALTH

CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Rev. 12/16

III. Responsibility for Payment

1. I agree to accept full responsibility for payment of all charges related to my care including charges for room and board, if applicable. I understand that a list of the usual and customary charges for room and board and other common charges is available to me upon request. Screening and stabilizing treatment for any emergency medical condition will not be delayed or conditioned upon my ability to pay, method of payment or insurance status.
2. I understand that I am responsible for any amounts not paid by my health insurance or any other insurance plan or policy, including but not limited to, any deductibles, copays, and coinsurance amounts provided under any coverage source, and charges for which there is no coverage source.
3. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of my medical information to my health insurance plan regarding those services, I understand that a separate financial agreement will be put into place regarding the self-pay services and Section IV below **will not** apply.

IV. Financial Agreements / Assignment of Benefits / Authorized Representative / Agent

1. I assign Mercy Health all rights to benefits, insurance payments, insurance reimbursements or other payments or judgements to which I may be entitled for services provided to me at Mercy Health facilities. I authorize Mercy Health to bill my insurance and assign the payment of these benefits directly to Mercy Health.
2. I assign all rights to benefits, insurance payments, insurance reimbursements or other payments or judgments to which I may be entitled for hospital-based physician services (pathology, radiology, cardiology, etc.) and/or emergency department services to the physician or organization providing the professional service. I also authorize submission of a bill for professional services to my insurance for payment.
3. I authorize and designate Mercy Health as my authorized agent and representative with the power to act on my behalf with respect to all matters related to all of my rights, benefits, privileges, protections, claims, causes of action, interests or recovery arising out of any coverage source, including but not limited to the ability to request reconsideration and/or appeal payment decisions made by any group health plan, employee benefits plan, health insurance plan , any other insurance plan or utilization review entity for coverage or grievance review (the "plan"). This includes, without limitation, the authority and right to: file medical claims with the plan; file appeals and grievances with the plan; request verification of coverage or pre-certification or authorization; file pre-service and post-service claims; request any and all information and documents under which the plan is established or operated; request any and all policies, procedures and guidelines and protocols considered by the plan in connection with the benefit claim determination; and to institute any litigation and/or complaints against the plan naming me as the plaintiff in such litigation if necessary.
4. I designate, authorize and convey to Mercy Health to the fullest extent permissible under law under any applicable plan the right and ability to act as my Authorized Representative with respect to benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.503-1(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Mercy Health. This includes, without limitation, the right and ability to act on my behalf in connection with any claim, appeal right, cause of action, including without limitation, any claim that may be brought pursuant to ERISA, that I may have under the plan; and the right and ability to act on my behalf in connection with any claim, right, or cause of action including litigation against the plan (even to name me as a plaintiff in such action) that I may have under such plan, I understand I can revoke this authorization in writing at any time.

5. I authorize Mercy Health to release my medical information (including medical information in my Mercy Health record relating to services provided to me by third parties) or other information, if required to obtain payment from my insurance or other payer and their agents to process payments.
6. I authorize Mercy Health to release my medical or other information to government agencies or their designees for review of the care provided to me.
7. Your treating physician/practitioner may order services or items that require upfront approval from your insurance company before you receive the services or items. I agree to cooperate, aid and assist Mercy Health in obtaining all possible insurance benefits for such services or items (for example: completing an application for insurance, providing timely information as requested).
8. If I make an application for Financial Assistance according to Mercy Health internal policies, Mercy Health is permitted to provide information as necessary to determine whether I am eligible for Financial Assistance.

V. Notice of Privacy Practices / Release of Information

1. I have been provided and/or offered a copy of the current Notice of Privacy Practices. I understand that the Notice of Privacy Practices outlines how my medical information may be used and disclosed, that Mercy Health will request my authorization where required, and that I have a right to request a restriction to its release.

VI. Communication to Patients

1. I consent to receive, on the cellular phone or other telephone number(s) that are listed on this form (or that are hereafter provided) text message, telephone calls or other communications for any purpose related to my current or prospective medical care, current or upcoming services offered by any authorized caller, or my account. I understand that these communications may be made using live, artificial or prerecorded voices, automatic telephone dialing systems, text message systems, e-mails or any other computer-aided technologies. I also understand that these communications may come from Mercy Health and its affiliates, clinical providers, affiliated physicians, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. This consent is not required to receive services from Mercy Health or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent at any time.

I consent [initials: _____] I do not consent [initials: _____]

VII. Responsibility for Patient Valuables

1. I agree while in the hospital to accept sole responsibility for the safety of my money and personal property (examples: electronics, dentures, eyeglasses, clothing, jewelry, etc.) and understand Mercy Heath is not liable for the safety, security or loss of money or valuables. If possible, these items should be sent home.

MERCYHEALTH

CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Rev. 12/16

VIII. Medicare, Medicaid & Other Insurance Certification

1. I certify that the information given by me in applying for payment under the Medicare Program of Title XVIII of the Social Security Act or Medicaid Program is correct. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services or its intermediaries/carriers or any commercial insurance carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

IX. Patient Agreement

I have read this Authorization /Consent for Treatment, Payment and Health Care Operations form or have had it read to me, and it has been explained to my satisfaction. I understand that this consent for Treatment, Payment and Health Care Operations applies to all Mercy Health facilities (such as hospitals, emergency departments, clinics, etc.) except where a separate consent may be required for an encounter.

By signing this document, I confirm that I accept the terms of this document, and confirm that any questions have been asked and answered. I further certify that I am the patient or his/her duly authorized representative, and that I am signing voluntarily.

Print: _____ Relationship: _____ Initials: ____ Date: _____ Time: _____
Patient or Legal Guardian or Patient Representative

Signature: _____ Relationship: _____ Initials: ____ Date: _____ Time: _____
Patient or Legal Guardian or Patient Representative

Print: _____ Date: _____
Witness

Signature: _____ Date: _____
Witness

Legal Guardian signed because: [___] Patient is a minor [___] A Guardianship has been established

Patient is unable to sign because: _____

Non-discrimination statement

Mercy Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, ethnicity, religion, sex, national origin, sexual orientation, age, ancestry, disability, veteran era status, or any person with HIV infection, whether asymptomatic or symptomatic, or AIDS, in any manner prohibited by the laws of the state and the United States, or in the treatment of patients. Mercy Health does not exclude people or treat them differently because of race, color, ethnicity, religion, sex, national origin, sexual orientation, age, ancestry, disability, veteran era status, or any person with HIV infection, whether asymptomatic or symptomatic, or AIDS.

MERCYHEALTH

CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Rev. 12/16

Language Interpreters

Mercy Health provides free aids and services to people with disabilities to communicate effectively with us such as:

- Qualified sign language interpreters
- Written information in other formats (large print, Braille, audio, accessible electronic formats, other formats)

You can contact the person at the registration desk to receive information on how to obtain the free aids and services for persons with disabilities or access the interpretation services.

All patients have access to interpretation services 24/7 at no personal cost to them.

- ¿Habla español? Le proporcionaremos un intérprete sin costo alguno para usted.
- 您讲国语吗？我们将免费为您提供 翻译
- Sprechen Sie Deutsch? Wir stellen Ihnen unentgeltlich einen Dolmetscher zur Verfügung.
- هل تتحدث اللغة العربية؟ سوف نوفر لكمترجمًا فوريًا بدون أي تكلفة عليك.
- Вы говорите по-русски? Мы абсолютно бесплатно предоставим вам переводчика.
- Parlez-vous français ? Nous vous fournirons gratuitement un interprète.
- Quý vị nói được tiếng Việt không? Chúng tôi sẽ cung cấp một thông dịch viên miễn phí cho quý vị.
- 한국어를 사용하십니까? 무료로 통역 서비스를 제공해 드리겠습니다.
- Parla italiano? Le forniremo gratuitamente un interprete.
- 日本語を話しますか？ 個人的な負担なしで通訳を提供致します。
- Ви розмовляєте українською? Ми абсолютно безкоштовно надамо вам перекладача.
- Vorbiţi româneşte? Vă vom asigura gratis un interpret.

Complaints and Grievances

If you believe Mercy Health has failed to provide these services or discriminated in another way on the basis listed above, you can file a grievance. Mercy Health can provide a copy upon request of its grievance filing procedures and contact information for individual(s) who can assist in filing and addressing the grievance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509 F, HHH Bldg, Washington DC 20201 1-800-368-1019 or 1-800-537-7697 (TDD)

MERCYHEALTH

HIPAA AUTHORIZATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner for appointments and test results (check **all** that apply)

□ Home/Cell telephone Home / Cell Number _____

___ Leave message with appointment date and time
___ Leave message with test results
___ Leave message with call back number only
___ Do not leave message

□ Work telephone Work Number _____

___ Leave message with appointment date and time
___ Leave message with test results
___ Leave message with call back number only
___ Do not leave message

□ Written communication

___ Mail to my home address _____

___ Mail to my work address _____

Patient / Parent Signature _____ Date_____

Print name_____ Patient date of birth_____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of, disclosure of, and the requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for reasons other than treatment, payment or operations may be permitted without prior consent in an emergency.

The following names listed are those that I give Mercy Health the authorization to give health information regarding blood work, appointments, test results and patient billing to:

Name	Relationship	Phone

___ DO NOT PROVIDE health information regarding my blood work, appointments and test results to anyone but me.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Signature of Patient/Legal Guardian_____ Date _____

Below to be completed if patient refuses to sign this acknowledgement:
Date_____ Name of person providing notice _____

This authorization is effective for one year from the date of origin.