

## **ORAL HEALTH SERVICES CONSENT FORM 2017-2018**

Garden Place Academy Oral Health Screen	ings January 29, 30, 31	& February 1, 2018	Grade:	Teacher:
The American Academy of Pediatric Dentis (Tepeyac) has offered to provide fluoride va this form will give consent to Tepeyac to p one in the spring. This preventive care does	rovide up to <b>two (2)</b> flu	ur child this year in th Ioride varnish treatm	e fall and the Spring, as p	out of the Destitute of the contract of the co
There will be no charge to the parent/lega on the enclosed registration form.	lly authorized represen	ntative for these serv	ices. You WILL need to re	egister your child with Clínica Tepeyac
YES, I want my child to receive an oral he NO, I do not want my child to receive an	ealth screening and fluc oral health screening o	oride varnish treatme or fluoride varnish trea	nt. atment.	
My signature below indicates that I have re	eviewed, understand th	ne information and ag	gree to the terms and co	nditions outlined.
Guardian Print Name:		n Signature:		Date:
Sliding Fee Scale				
Tepeyac screens all patients for availability of is based on income and family size. By comp  Refuse to Report Family Size and Income	pleting the information	a sliding fee scale for below you will be giv	those patients who do no en the discount for a 12 r	nt have insurance. The sliding fee scale month period.
Family Size				
Yearly Family Gross Income				
Student Information (Print all information in	ink)			
Patient Student Full Name	First:	Midd	ile:	Last:
Patient Student Full Name  Date of Birth	First: Month:	Mido	fle: Year:	Last:
		Day:	-	L == 1 == 1 = 1 = 1
Date of Birth	Month:	Day:	Year:	Lancas inc.
Date of Birth  Patient Student Medicaid/Insurance Plan	Month:  Medicaid/Insurance F	Day: Plan Name:	Year:	Lancas inc.
Date of Birth  Patient Student Medicaid/Insurance Plan  Patient Sex	Month:  Medicaid/Insurance F	Day: Plan Name:	Year:	Lancas inc.
Date of Birth  Patient Student Medicaid/Insurance Plan  Patient Sex  Home Address	Month:  Medicaid/Insurance F	Day: Plan Name:	Year:	Lancas inc.
Date of Birth  Patient Student Medicaid/Insurance Plan  Patient Sex  Home Address  City/Zip Code	Month:  Medicaid/Insurance F	Day: Plan Name:	Year:	Lancas and the same
Date of Birth  Patient Student Medicaid/Insurance Plan  Patient Sex  Home Address  City/Zip Code  Preferred Phone Number	Month:  Medicaid/Insurance F  Male  City:	Day: Plan Name: Female Zip:	Year: Medicaid/ Plan ID#	Lancas and the same
Date of Birth  Patient Student Medicaid/Insurance Plan  Patient Sex  Home Address  City/Zip Code  Preferred Phone Number  Student's Main Language	Month:  Medicaid/Insurance F  Male  City:  ( )  English	Day:  Plan Name:  Female  Zip:  Spanish  Middle:  askan Native	Year:  Medicaid/ Plan ID#	: No Insurance
Date of Birth  Patient Student Medicaid/Insurance Plan  Patient Sex  Home Address  City/Zip Code  Preferred Phone Number  Student's Main Language  Guardian/Parent Name	Month:  Medicaid/Insurance F  Male  City:  ( )  English  First:  American Indian/Ala Asian Native Hawaiian /Pa	Day:  Plan Name:  Female  Zip:  Spanish  Middle:  askan Native  acific Islander ican	Year:  Medicaid/ Plan ID#  Other  Last:  White Hispanic Unreported/Refe	: No Insurance
Date of Birth  Patient Student Medicaid/Insurance Plan  Patient Sex  Home Address  City/Zip Code  Preferred Phone Number  Student's Main Language  Guardian/Parent Name  Student Race	Month:  Medicaid/Insurance F  Male  City:  ( ) English  First:  American Indian/Ala Asian Native Hawaiian /Pa Black/African Ameri  Hispanic/Latino	Day:  Plan Name:  Female  Zip:  Spanish  Middle:  askan Native  acific Islander ican	Year:  Medicaid/ Plan ID#  Other  Last:  White Hispanic Unreported/Refu	: No Insurance
Date of Birth  Patient Student Medicaid/Insurance Plan  Patient Sex  Home Address  City/Zip Code  Preferred Phone Number  Student's Main Language  Guardian/Parent Name  Student Race  Student Ethnicity	Month:  Medicaid/Insurance F  Male  City:  ( ) English  First:  American Indian/Ala Asian Native Hawaiian /Pa Black/African Ameri  Hispanic/Latino  or is your child under the	Day:  Plan Name:  Female  Zip:  Spanish  Middle:  askan Native  acific Islander ican	Year:  Medicaid/ Plan ID#  Other  Last:  White Hispanic Unreported/Refu	: No Insurance

Allergies
Yes No Does your child have any allergies to food or medicine? Yes No Does your child have any allergies to pine nuts or colophony (colophonium)? Yes No No Has your child ever had a reaction to latex? Yes No Does your child have any heart problems?
Consent for Health Services/Treatment
I understand that I will be notified of any services my child receives, as well as any abnormal findings and/or further treatment recommendations. I give permission for my child to get dental screenings and fluoride varnish at the school site. I also understand I should contact the school nurse if I have questions about any necessary follow-up care or instructions. I understand this consent will remain valid throughout the 2017-2018, 12- month academic year unless revoked by me. I may revoke this consent for treatment at any time by requesting in writing that to remove my child from receiving oral health screenings/services. It is my responsibility to notify the school nurse of all updates or changes to my child's health condition(s), immunization records, medications or insurance coverage. I give permission for Medicaid or CHP+ to be billed for the above services. I realize I can take my child to another dentist at any time. I understand that this screening and the fluoride varnish treatment are preventative treatments, and cavities can still form without adequate oral hygiene and routine care. Dental care will be performed by a Tepeyac's hygienist.
Privacy Practices & Authorization to Release Information
HIPAA Notice of Privacy Practices: The notice provides information on use of your health information and rights. The notice outlines when we will release your health information with or without your consent. I understand that the full notice is available upon request. I also can view the notices online at: <a href="www.clinicatepeyac.org">www.clinicatepeyac.org</a> .
Authorization to Release Information: I hereby authorize Tepeyacto exchange information with Swansea Elementary school nurse(s), school counselor(s) and/or school social worker(s) for the exclusive purpose of treatment or care coordination. My child's records are protected and can only be accessed by authorized users with restricted access. I understand this authorization will remain valid throughout the 2017-2018, 12-month academic year unless revoked by me. I may revoke this authorization at any time by providing written notice of my intent to revoke to oral health screenings/services
I also understand that my child's personal information will be kept confidential and will not be shared with any person who is not directly involved in the care of my child. I also understand that I would need to sign a release for the information to be shared with anyone not directly connected to Clínica Tepeyac or the school as part of the Health Insurance Portability & Accountability Act (HIPAA). I also understand that I would need to sign a release for information about my child's student education records with anyone not directly connected to Clínica Tepeyac or the school as part of the Family Educational Rights and Privacy Act (FERPA). I understand that this screening and the fluoride varnish treatment are preventative treatments, and cavities can still form without adequate oral hygiene and routine care.
Privacy Practices & Authorization to Release Information  Please check which insurance carrier covers your child or sign below if you don't think your child has insurance. Some oral health screenings are provided at no cost to families whether or not a student has insurance or the ability to pay.
Health First Colorado (Medicaid) Child Health Plan Plus (CHP+) Plan ID #:
The student does not have health insurance.  Private Insurance (other than Medicaid) Plan Name:
It is very important that everyone has a health care provider to see regularly for both sick visits and well visits. Clínica Tepeyac wants to help you find a medical home for all your primary care needs. Clínica Tepeyac prides itself in serving the community and providing quality medical care to all patients in need regardless of where they live, their income status (ability to pay) or their insurance plan. Our charges and fees are based on income.
Your family will be registered into our system and eligible to receive services. If you have any questions or concerns, please contact Clínica Tepeyac at (303) 458-5302 to speak with a team member.