Honor Community Health
Mobile Dental Services Consent

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Honor Community Health may use and disclose protected health information (PHI) about me to carry out Treatment, Payment, and Operations (TPO). Please refer to Honor Community Health's Notice of Privacy Practices posted in the clinic for a more complete description of such uses and disclosures.

Honor Community Health observes the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Honor Community Health at 461 W. Huron, Pontiac, MI 48341-1601.

With my consent, Honor Community Health may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

Honor Community Health may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

Honor Community Health may email or text me appointment reminders and patient statements. I have the right to request that Honor Community Health restrict how it uses or discloses my PHI to carry out the TPO. However, the center is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Honor Community Health's use and disclosure of my PHI to carry out TPO. I understand that I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance to my prior consent. If I do sign the consent, Honor Community Health may decline to provide treatment to me.

I consent to the person(s) listed below having access to my entire Personal Health Information (PHI). I also authorize Honor Community Health to talk about my entire PHI to the person(s) listed below:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

I give permission to the individual listed below to bring my children to their healthcare appointments and pick-up medication from the pharmacy:

Name: _____ Relationship: _____ Phone #: _____

X_____ _____
Signature of Patient or Patient's Legal Guardian (if applicable) Date

_____ _____
Print Patient's Name Print Name of Patient's Legal Guardian (if applicable)

Honor Community Health
Mobile Dental Services Consent

CONSENT FOR TREATMENT

I hereby consent to all treatment, including tests, evaluation, procedures, and medications deemed necessary by the clinicians and staff of Oakland Integrated Healthcare Network (OIHN) DBA Honor Community Health.

I understand clinicians and staff will depend on statements I make, information in my health history, and other information as available to evaluate my condition and decide on the best treatment.

I understand that clinicians and staff will discuss the benefits and risks of treatment with me, and that I can ask questions about my treatment or the protection of my health records at any time.

I understand that I have the right to refuse any procedure or treatment.

I understand that OIHN maintains an integrated health record which contains health information regarding all of the services I receive from OIHN (medical, behavioral health, substance use, dental, etc.). Any OIHN clinician or staff member I interact with will have access to my integrated health record, this includes any applicable substance abuse treatment records.

I understand that some services at OIHN may be provided using telemedicine equipment and involve interactions with providers who are not physically present for my appointment. These sessions are transmitted via a secure, dedicated connection and are not: videotaped, routed through the internet, recorded, or saved in any way. However, relevant information will be documented in my health record, just as it would be if the provider had been physically present. I understand that at any point I can decide that telemedicine sessions are not meeting my needs and request an in-person appointment.

I agree to pay any charges at the time of service or upon receipt of statement.

I understand that this consent shall remain valid for a period of one year from the date below unless I withdraw consent, or the program has already acted on it. All consents must with withdrawn in writing with the exception of consent for substance abuse treatment which can be withdrawn verbally.

I agree that I have been provided adequate information and the chance to have questions answered.

X _____ _____

Signature of Patient or Patient's Legal Guardian (if applicable) Date

_____ _____

Print Patient's Name Print Name of Patient's Legal Guardian (if applicable)

HONOR Community HEALTH
Live healthy. Be well.

Honor Community Health
Mobile Dental Services Consent

Name of School:		Child's Grade:		Child's DOB	
Child's First Name:		Middle Name:		Last Name:	
Street Address:				Apartment/Unit #	
City:		State:		Zip Code:	
Home Phone:		Cell Phone:		Work/Alt Phone:	
Date of Birth: (month/day/year)	_____/_____/_____		Gender at Birth:	☐ Male	☐ Female

Current Gender:	☐ Male	☐ Female	☐ Transgender Male (Female to Male)
	☐ Transgender Female (Male to Female)	☐ Other	☐ Choose not to Disclose

Sexual Orientation:	☐ Straight/Heterosexual	☐ Something Else	Preferred Language:	☐ English
	☐ Lesbian or Gay	☐ Don't Know		☐ Spanish
	☐ Bisexual	☐ Choose not to Disclose		☐ Other: _____

Race:	☐ American Indian/Alaskan	☐ Asian	☐ Black/African American
	☐ Native Hawaiian/Other Pacific Islander	☐ White/Caucasian	☐ Refuse to Report
Ethnicity:	☐ Hispanic/Latino	☐ Not Hispanic/Latino	☐ Refuse to Report

Living Situation:	☐ I own/rent a home/apartment/condo		
	☐ Transitional Housing (I have been homeless in the past year, but have housing now/am in a treatment center)		
	☐ Doubling Up (Staying with friends/relatives because I have no other choice)		
	☐ Staying in a shelter (Short term housing such as HOPE, SOS, Haven etc.)		
	☐ Street (Living outdoors or in a car/camper)		
	☐ Other Homeless (Living somewhere not meant to be a home – no running water or heat etc.)		
	Are you worried about losing your housing?	☐ Yes	☐ No

Fluoride varnish can be painted on teeth to protect teeth from cavities. Fluoride varnish can be applied up to 4 times a year.

Health History: Please check all that apply to your child's health

☐ Anemia	☐ Anorexia/Bulimia	☐ Asthma	☐ Diabetes
☐ Diabetes	☐ Emotional Impairment	☐ Fainting	☐ Head Injury
☐ Learning Impairment	☐ Rheumatic Fever	☐ Sinus Problems	☐ Stomach Problems

☐ Other: _____

Allergies: Please list any allergies your child may have including allergies to medication:

_____

Medications: Please list all medications that your child takes:

_____

Consent: Fluoride varnish helps to remineralize the enamel helping to decrease decay. It can be applied up to 4 times a year.
Please check all options you give permission for your child to receive:

☐ Dental Assessment Exam ☐ Dental Cleaning ☐ Dental Sealants ☐ Fluoride Varnish ☐ X-Rays

Parent's Name:		Parent's Signature:	
Today's Date:		Parent's Email Address:	

HONOR Community HEALTH
Live healthy. Be well.

Honor Community Health
Mobile Dental Services Consent

Medicaid/Healthy Kids Dental/MIChild and other dental insurance carriers will be billed to help cover the cost of this program. Please fill out insurance information. Your 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 your child as part of the Health Insurance Portability and Accountability (HIPAA)

I, the parent/client, understand that treatment may be obtained at my child's dental home rather than by the PA 161 Program and that obtaining duplicate services may affect the benefits that I/my child receive from private insurance, a state or federal program, or third-party provider of dental benefits.

Medicaid #		Name of Dental Insurance:			
Insured Name:		Parent Name:		Date of Birth:	___/___/____
Group #:		Policy/ID #:		Insured SSN:	
Insured Employer:				Phone #	

Honor Cares: Sliding Fee Program

Honor Community Health offers discounted fees for qualified patients who may be unable to pay the full fee for services. As a non- profit organization, we receive funding from local, state, federal and grant funding sources and we are required to collect financial information from our patients to continue to receive this funding. All information will remain confidential.

Slide Category	A	B	C	D	E
	Locate the row describing your family size, then circle the corresponding income range. Example: For a 3-person household, with $30,000 total annual income:				
Family Size: Count Adult and Children	Total Household Income Range: Annual Earnings				
1 person living in household:	$0 to $13,590	$13,591 to $20,385	$20,386 to $23,782	$23,783 to $27,180	$27,181+
2 people living in household:	$0 to $18,310	$18,311 to $27,465	$27,466 to $32,042	$32,043 to $36,620	$36,621+
3 people living in household:	$0 to $23,030	$23,031 to $34,545	$34,546 to $40,302	$40,303 to $46,060	$46,061+
4 people living in household:	$0 to $27,750	$27,751 to $41,625	$41,626 to $48,562	$48,563 to $55,500	$55,501+
5 people living in household:	$0 to $32,470	$32,471 to $48,705	$48,706 to $56,822	$56,823 to $64,940	$64,941+
6 people living in household:	$0 to $37,190	$37,191 to $55,785	$55,786 to $65,082	$65,083 to $74,380	$74,381+
7 people living in household:	$0 to $41,910	$41,911 to $62,865	$62,866 to $73,342	$74,383 to $83,820	$83,821+
8 people living in household:	$0 to $46,630	$46,631 to $69,945	$69,946 to $81,602	$81,603 to $93,260	$93,261+
More than 8 people living within the household:	$4,720	$7,080	$8,260	$9,440	$9,441+
What is your income?	$_____	How often do you collect this income?	☐ Weekly	☐ Bi-Weekly ☐ Monthly	☐ Annually

☐ I confirm that the above information is truthful and accurate. I agree to inform Honor Community Health of any changes in my income. Failure to provide truthful, accurate and/or timely information may result in loss of funding for sliding scale privileges.

☐ I decline to apply for the Honor Cares Sliding Fee Program

X_____ _____ _____

Signature of Patient or Patient's Legal Guardian | Print Name of Patient's Legal Guardian | Date