Georgia Department of Public Health
District 4 Public Health

Brenda Fitzgerald, MD, Commissioner | Nathan Deal, Governor

Olugbenga Obasanjo, M.D., Ph.D., M.P.H.
District Health Director

122A Gordon Commercial Drive, LaGrange, Georgia 30240
Phone: (706) 845-4035 o www.district4health.org

Adult Dental Program

Application Packet

A completed application packet must be submitted before we will schedule you an initial Adult Dental Program visit. You may return the application packet to the Dental Clinic or to the Health Department or fax it to 770.358.1258.

Along with completing all of the forms in the application packet you must also provide a photocopy of your Medicaid/Peachcare Insurance Card, a photo ID and proof of income or support. Proof of income/support **must** be provided to participate in the sliding fee scale program.

Since proof of income/support **must** be provided to participate in the sliding fee scale program, if you are supported by an individual other than your legally married spouse, that person must agree to provide a photo ID, proof of income and personally come into the Health Department or Dental Clinic to write a brief statement that they are supporting you. This in- person visit allows us to verify the identity and agreement of the person providing support.
This statement and information will then become a permanent part of your record.

Payment in cash (NO checks) is due at the time of service.

District 4 Public Health
Serving Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup and Upson Counties

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Limited Adult Dental Services are available on a space available basis included dental exams, x-rays, simple fillings, simple extractions and cleanings.

A sliding-scale fee is available for the uninsured with proof of income.

The first visit will consist of an exam and any necessary x-rays needed in order to discuss treatment options. Any treatment that can be accomplished at our clinic will be scheduled for a future appointment. Patients with treatment needs that are more extensive than we provide here will be referred out to other dental providers or specialists. *There is a charge for the initial exam and x-rays, even if a referral for treatment is needed.*

Payment is expected PRIOR to receiving any services.

My signature bellows indicates that I understand and agree with the office policies outlined above.

_____ _____

Signature Date

Georgia Department of Public Health

District Four Health Services
Lamar County Dental Clinic
Georgia Oral Health Prevention Program

For Office Use Only

Medical Alert:_____
I have reviewed this Medical History:
_____**Name** _____**Date**

Name: Last First Middle			**Birth Date:**
Home Phone: ( ) **Cell Phone: ( )** **Work Phone: ( )**_____	**Sex:** M ☐ F ☐	**Age:**	**Social Security #** ☐☐☐-☐☐-☐☐☐☐

Race: **Black** ☐ **White** ☐ **Multiracial** ☐ **Asian** ☐ **Hispanic/Black** ☐ **Hispanic/White** ☐ **Amer.Indian/Alaskan** ☐ **Unknown** ☐

Address: Street City Zip	**County:**	**Are you married?** ☐ **Yes** ☐ **No**
Parent/Guardian Name or Emergency Contact		**ER Contact Phone:**
Has the patient ever been to the dentist? **Yes** ☐ **No** ☐		**Date of patient's last dental visit?**
☐ **Medicaid** ☐ **PeachCare** ☐ **Amerigroup** ☐ **PeachState** ☐ **WellCare**	**Member Number:**	

DOES PATIENT HAVE or HAS EVER HAD:

Yes	No		Yes	No	
☐	☐	**High Blood Pressure**	☐	☐	**Stroke**
☐	☐	**Cancer**	☐	☐	**Dental Anxiety or Fear**
☐	☐	**Asthma**	☐	☐	**Kidney Disease**
☐	☐	**Tuberculosis**	☐	☐	**Liver Disease**
☐	☐	**Diabetes**	☐	☐	**Thyroid Disease**
☐	☐	**Hepatitis**	☐	☐	**HIV or AIDS**
☐	☐	**Heart Murmur or Heart Condition**	☐	☐	**Rheumatic Fever**
☐	☐	**Epilepsy or Seizures**	☐	☐	**S. T. D.**
☐	☐	**Psychiatric Problems**	☐	☐	**Special Needs**
☐	☐	**Do you use tobacco?**	☐	☐	**Do you require antibiotics prior to dental treatment?**
☐	☐	**Blood Disease (Anemia, Sickle Cell Disease)**			
☐	☐	**Are you pregnant or think you may be?** ____**Number of weeks**	☐	☐	**Any complications?**
☐	☐	**Other Allergies or Drug Allergy? (Explain)**			
☐	☐	**Is patient under the care of a Physician for any medical condition? (Explain)**			
☐	☐	**Other severe illnesses, hospitalizations, or any condition not listed on this form? (Explain)**			
☐	☐	**Is patient taking ANY medication? LIST ALL Prescriptions and Over-the-counter:**			

CONSENT: I consent to dental treatment for myself or my minor child, which in the judgment of the medical or dental staff is necessary for oral health. This treatment may include but is not limited to the following: examination of teeth, sealant placement, prophylaxis (cleaning), scaling, fluoride application, restoration of teeth, extraction of teeth, x-rays, administration of drugs/local anesthetic, and/or other specialty treatments deemed necessary. I approve the release of my records to my insurance provider or other health care professionals as deemed necessary by the medical or dental staff. I authorize District Four Health Services to file claims and receive reimbursement directly from my insurance provider. I understand that this request for dental treatment is valid for as many years as I or my child is eligible for this service. I further **verify that the above medical history is true and accurate to the best of my knowledge** and I have received the District Four Health Services **NOTICE OF PRIVACY POLICY**. This permission can be revoked only by written notification to the Dental Program Administrator, District Four Health Services, 122-A Gordon Commercial Drive, LaGrange, Georgia.

Signature _____**Date**_____

***** Parent/legal guardian MUST SIGN medical history/consent BEFORE treatment begins for patients under 18 years of age.**

Attachment M

NOTICE OF PRIVACY POLICIES FOR DISTRICT FOUR HEALTH SERVICES

DISTRICT FOUR HEALTH SERVICES, 122A GORDON COMMERCIAL DR. LAGRANGE, GEORGIA 30240

Ph. 706/845-4035

Notice of Health Information Practices

THIS NOTICE OF HEALTH INFORMATION PRACTICES DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Introduction

It is important to us that you understand what information we collect about you and how it is used. We want you to know that we limit the collection and disclosure of information to only that which we believe is necessary to serve you and administer our business.

This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit the health department a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

1. A basis for planning your care and treatment.
2. A means of communication among the many health professionals who contribute to your care.
3. A legal document describing the care you received.
4. A way that you or a third-party payer can verify that services billed were actually provided.
5. A tool in educating health professionals.
6. A source of data for medical research.
7. A source of information for public health officials charged with improving the health of this state and the nation.
8. A source of data for our planning and marketing.
9. A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.
10. A source of supporting data, which allows us to receive state and federal funding to provide public health services.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy. You can better understand who, what, when, where, and why others may access your health information. It allows you to make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the property of the health department, the information belongs to you. You have the following rights:

1. To receive a paper copy of this notice of information practices upon request.
2. To inspect and/or receive a copy of your health record.
3. To request an amendment to your health record
4. To receive an accounting of disclosures of your health information.
5. To request communications of your health information by other means or at other locations.
6. To request a restriction on certain uses and disclosures of your information.
7. To revoke your authorization to use or disclose your health information except to the extent that action has already been taken.

Our Responsibilities

The health department is required to:

1. Maintain the privacy of your health information.
2. Provide you with this notice of our legal duties and privacy practices regarding information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Notify you if we are not able to agree to a requested restriction.
5. Agree to reasonable requests from you to deliver health information in other ways or at other locations.

We reserve the right to change our practices and to make those changes effective for all protected health information we maintain. Should our information practices change, we will post the revised notice in our facility and provide you with a copy on request.

We will not use or disclose your health information without your permission except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

D4 R/R 2/09

I have received the Notice of Health Information Practices from [County] Board of Health

I prefer to limit the disclosure of my health information and desire to speak with the [County] Board of Health Privacy Officer.

Signature:_____ Date:_____

If signed by someone other than the patient, please state relationship to patient. _____

For More Information or to Report a Problem
If you are comfortable with the content of this policy and will allow us to exchange information about you as outlined, then you need only to sign the acknowledgement attached. If you prefer to limit disclosure of information about you, please note that on the acknowledgement form and contact the [County] Board of Health Privacy Officer for further information.

If you believe your privacy rights have been violated, you can file a complaint with the health department's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations
We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. If you receive additional treatment from another physician, hospital, or laboratory we may share information with that provider about services you received in this facility .

We will use your health information for payment.

For example: A bill may be sent to you, a health insurance company, Medicaid or Medicare. The information on or with the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We may contact or share information with other providers for payment services.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples are the providers of our computer software where electronic records are kept. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Planning/Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that that you may be eligible for.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. We may also disclose your health information to support funding from state and federal grants for the various public health services we provide and the administration of public health services.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

D4 R/R 2/09

I _____ gave the Notice of Health Information Practices to
(Employee Name)
_____ on _____ and he/she refused to sign the acknowledgement of receipt.
(Client Name) (Date)

Declaration of Income and Insurance Information form

Some programs offer reduced fees based on income. To apply for a reduced fee, please provide the following information:

Number of family members in the household: _____

Total family income: $ _____ per Week or Month or Year (Circle One)

Check which method of income verification applies to you:

**☐ Proof of Income (example: pay stub, W2, letter from DOL): _____

☐ Self-Declared income (for Family Planning and STD clients only)

I have health insurance coverage with the following: (Check all that apply)

☐ Medicaid

☐ Wellcare ☐ Peachstate ☐ Amerigroup

☐ Medicare

☐ Private Insurance

☐ I do NOT have health Insurance

☐ I do NOT have dental Insurance

My health insurance is NOT applicable due to the following: (Check all that apply)

☐ I am a Native American receiving healthcare services through the Indian Health service or a tribal organization

☐ I am in a period of exclusion under my health insurance plan

☐ I have exhausted my lifetime limits under my insurance plan

☐ I have limited scope coverage such as dental, vision, long term care or coverage for specific illnesses, not including family planning and/or breast and cervical cancer screening

☐ I have health insurance via a self-insured company that does not provide coverage for family planning and/or breast and cervical cancer screening

I understand that I may be asked to provide written proof of any insurance exclusion as indicated above (does not apply to family planning services). I understand that if I have insurance or fail to disclose insurance information, I will be held responsible for payment of services provided.

I understand that qualifying for any special discounted fees will be based upon the information regarding my income and number of dependents as listed above. I verify that the information I have given above is current and accurate. My signature below indicates that I have read or have had read to me the above regulations. I have had an opportunity to ask questions and understand the guidelines as listed above.

_____ _____

Client Signature Date

_____ _____

Interpreter Date

_____ _____

Health Department Witness/Title Date