Preventive Dental Care

Provided **in-school** and **at no cost to parents**

(If you have insurance, we will ask your insurance provider to help cover our costs)

And, all **YOU** have to do is fill out this short form and return it to your child’s teacher!

Student’s Name: ______________________________________

(Last)       (First)       (Middle)

Parent/ Guardian: ______________________________________

Best time to reach Parent/Guardian: Morning ☐  Afternoon ☐

Best number to reach Parent/Guardian:

☐ Home phone: __________________________

☐ Cell phone: __________________________

☐ Work number: _________________________

Do you have Dental Insurance?  Yes ☐  No ☐

*note: Medicaid covers dental care.

Name of Dental Insurance: ____________________________

Policy #: _________________________________________

(more on the other side)

Preventive dental services include: dental cleaning, dental sealants, dental screening and fluoride treatments.

More information about this program is available on the Lowville Academy website

All students can use Lowville’s School-Based Dental Program

Any student can receive dental services through the School-Based Dental Program.

There are no eligibility or income requirements.

Preventive dental care is provided by North Country Family Health Center, a federally qualified community health center with offices in Watertown and Lowville.
School-Based Health/Dental Program
2015-16 ENROLLMENT FORM

Student’s Name: ____________________________
(LAST) (FIRST) (FULL MIDDLE)

Student’s School: ____________________________ Grade: _____ Teacher/Homeroom: ________________

☐ I would like to enroll my child in the PREVENTIVE dental program at my child’s school
to receive dental screenings, cleanings, fluoride treatments and sealants.

CONFIDENTIALITY (HIPAA) NOTICE

North Country Family Health Center is committed to maintaining the privacy of your protected health information (PHI). Our promise is that your medical records and other PHI will only be released from our practice with a properly executed authorization form from you, the patient, or your representative, except for certain instances. These instances are described in our Notice of Privacy Practices. The Notice is available for you to read in our office and you may have a copy if you ask us for one. The following are possible ways in which we may use or disclose your PHI: These are only examples. You may read the entire Notice by asking any employee.

1. When our medical/dental staff is caring for your child, we will review your child’s medical/dental history.
2. Our administrative staff may audit your child’s medical/dental records for completeness.
3. We may need to tell your insurance plan certain information so that we may receive payment for services.

You have a right to review the Notice before signing this consent. You have the right to ask us to restrict how we use your PHI. We will provide you with a form on which you can make your written request for restrictions. We don’t have to agree to the restriction, but if we do, we are bound by the agreement. We may make changes to the Notice. Upon your request, we will provide you with any revisions. By signing this form you consent to our use and disclosure of protected health information (PHI) as described in our Notice of Privacy Practices. You have the right to revoke this consent in writing. You have the right to an accounting of the disclosures of your PHI for other treatment, payment and health care operations.

I have been informed and understand my rights regarding the possible ways in which North Country Family Health Center may use and disclose my/ my child’s protected health information.

Parent/Guardian Signature: ____________________________ (If child is 18 they may sign for themselves) Date: ________________

CONSENT FOR SCHOOL-BASED DENTAL SERVICES:

I give my consent for my child, ____________________________, to receive services provided by the staff of the North Country Family Health Center (NCFHC) School-Based Health/Dental program. I give my permission for the release of my child’s reports to his/her dental provider and the appropriate information from the dental exam to the school nurse. If applicable, I authorize NCFHC to bill my insurance company, including Medicaid, CHP/FH, and private insurances. I authorize insurance and/or Medicaid payments for services rendered for my dependent to be paid directly to NCFHC and the release of medical information necessary to process claims to my insurance carrier.

Services may include, but are not limited to, the following: dental screening, dental cleaning, and the application of fluoride varnish and/or dental sealants.

I understand that every effort will be made to contact me prior to treatment. The staff of the North Country Family Health Center believes that parental involvement is essential in keeping children healthy. We encourage parents with questions or concerns to contact NCFHC’s School-Based Dental Program Clinical Lead Nicole Quintin at (315) 782-9450 ext. 8034.

Parent/Guardian Signature: ____________________________ Date: ________________