School-Based Oral Health Program
Kari A. Cunningham, DMD, FAAPD
26250 Euclid Ave. Suite 203 Euclid, OH 44132
Phone: 216-938-8501 Fax: 216-938-8502
www.pantherpediatricdentistry.com

School:_____

Teacher:_____

Grade/Class:_____

Join our Panther Pediatric Dentistry School-Based Oral Health Program (S-BOHP)

A pediatric dentist from Panther Pediatric Dentistry (PPD) will come to your child's school to provide a complete dental examination to check your child's mouth and teeth. Members of our Panther Pride will perform a cleaning, fluoride application (tooth vitamins), and apply sealants, as necessary. We may try to slow down cavities that are forming by placing Silver Diamine Fluoride (SDF) to your child's back tooth/teeth. Once done, your child will receive a goodie bag of smile supplies, a report card of the work completed, as well as a description of our findings. If your child has treatment needs that we can fulfill, we would be happy to see them at our Panther Pediatric Dentistry office in Euclid!

Child's Legal Name:_____ Date of Birth_____ Gender:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Parent/Guardian Name:_____ Phone:_____

Parent Birthdate:_____ Email:_____ Other Phone:_____

Health History - It is important that we know if your child has had any past or present medical conditions, mental or behavior conditions, allergies, or challenges with dental treatment. Please check each condition that applies to your child and give us details in the space provided. *If no conditions apply to your child, please leave this section blank.*

	ADD/ADHD		Autism		Diabetes		Immune disorders		Premature birth
	Allergies - food		Behavior condition		G6PD deficiency		Kidney disease		Seizure disorder
	Allergies - medicine		Blood disorder		GI disorders		Liver disease		Sickle cell anemia
	Allergies - seasonal		Breathing problems		Head injury		Mental disorder		Silver allergy
	Asthma		Dental problems		Heart disease		Past surgeries		Unknown (foster/adoption)

Other/Explain:_____

Medications taken:_____

◯ **My child has Ohio Medicaid.** Please circle the plan: OH Medicaid, CareSource, Molina, Buckeye, United HealthCare.

My Child's Member ID / Subscriber ID Number:_____

◯ **My child has Private Dental Insurance** Please circle the plan: Cigna, Delta Dental, GEHA/Connection Dental, Guardian, MetLife, and Team Care. PPO plans ONLY (no HMO or DHMO plans accepted).

Ins. Company:_____ Ins. Phone_____ Group #:_____

Employer Name:_____ Company Phone:_____

Name of Insured Adult:_____ Birthdate of Insured Adult:_____

Member ID/Policy#:_____ Social Security # of Insured Adult:_____

◯ **My child DOES NOT have dental insurance**, or our insurance is not in network with Panther Pediatric Dentistry

If you wish to have your cub receive an exam, cleaning, and fluoride at school, for a low fee, please check here. This fee of $62.00 must be paid in advance via credit/debit card by calling our office at 216-938-8501.

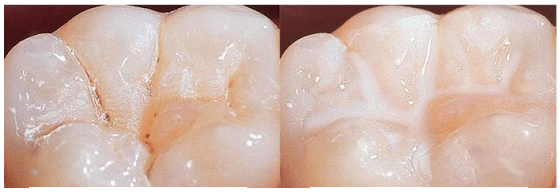
If your child has an established dental home, you can choose to continue seeing that provider and not join the S-BOHP.

I, the parent/legal guardian, authorize the Panther Pediatric Dentistry team to perform an examination, dental cleaning, fluoride treatment, sealant placement, and/or silver diamine fluoride placement, as needed on my child based on their clinical findings. I understand that silver diamine fluoride will slow down the cavity process in my child's teeth and may color any active cavities black, permanently. I have read the Health History above and completed it truthfully and to the best of my knowledge. I will advise Panther Pediatric Dentistry of any health changes by calling them at 216-938-8501. I have read the Consent for Treatment, Insurance and Financial Policies, and received a copy of the Notice of Privacy Practices. By signing below, I acknowledge that I understand and agree to the terms of the policies. I may withdraw my consent at any time by calling Panther Pediatric Dentistry at 216-938-8501.

Parent/Guardian Signature:_____ Date:_____

This consent authorizes the initial and future dental visits and participation in the Panther Pediatric Dentistry S-BOHP

Consent for Treatment: I, the parent/legal guardian, authorize the Panther Pediatric Dentistry School-Based Oral Health Program to perform an examination (visual checkup), dental prophylaxis (cleaning), fluoride treatment (tooth vitamins), and place sealants (a plastic, protective material) on eligible teeth as part of a comprehensive preventive dental treatment plan for my child. I understand that sealants are placed to aid in preventing decay (cavities) from forming on permanent molars (adult back teeth).



Before Sealant After Sealant

I, the parent/legal guardian, authorize the PPD S-BOHP to place Silver Diamine Fluoride (SDF) on my child's tooth/teeth that show signs of decay. I understand that SDF will stain active decay brown or black, permanently. Placing SDF helps to slow down the decay process and is not a substitute for treatment (fillings, crown, extraction, etc.). SDF cannot be placed on children with an allergy to silver and who have open sores in their mouth.

☐ Check here if you **DO NOT WANT** your child to have SDF.

Signature (Parent/Legal Guardian):_____ **Date:**_____

Insurance Policy: I understand that it is my responsibility to make sure all insurance information is accurate (including primary and secondary insurances) at all times and I will notify Kari A. Cunningham, DMD, LLC (dba: Panther Pediatric Dentistry S-BOHP) of any changes that may occur. Failure to provide accurate information could result in denied claims and payment will be expected to be paid in full by the parent/guardian at the office's standard rate described in the treatment plan. I agree to disclose all dental insurances for my child. If I fail to advise Kari A. Cunningham, DMD, LLC that my child has multiple dental insurance policies and an insurance claim is denied because the insurance company indicates that a primary dental insurance exists for the patient, I may be issued a statement for the unpaid services for the patient at 100% of the standard fees of the practice.

Panther Pediatric Dentistry School-Based Oral Health Program Detailed Financial and Collections Policy (effective 5/1/2022)

The daily operation of Kari A. Cunningham, DMD, LLC (DBA: Panther Pediatric Dentistry S-BOHP) depends upon reimbursement from patients, and/or their insurance company for the costs incurred while providing dental care for children. For the children with insurances for which Dr. Kari A. Cunningham is a provider, the practice will do its best to provide the parent/guardian with an estimate of costs associated with treatment.

There are times when the recommendation of preventive or restorative care exceeds the limitations set forth by the policy of an insurance plan. We will do our best to capture that information in advance from the insurance company when we draft treatment plans based on the individual needs of the patient. However, the parent/guardian/guarantor is ultimately responsible for the costs not covered by the insurance company.

Any deductibles, copayments, and estimated patient payments are to be collected at the time services are rendered. As a courtesy, our office will file insurance claims for primary and secondary insurances ONLY. Individuals with a tertiary dental insurance plan will be handled on a case-by-case basis by our Office Coordinator.

Payments received by our office from the insurance company will be applied to the patient account. Any remaining balance on the account, will be billed to the parent/guardian/guarantor in the form of a statement that is due within two (2) weeks from the date the statement was sent. Statements will be sent monthly at intervals of 30, 60, and 90 days past due. Phone calls will be made by our office in an attempt to reach the responsible party and collect the debt after the due dates of each statement sent. In the event the balance has not been paid and the account is at least 120 days past due, Kari A. Cunningham, DMD, LLC will add a $30 fee prior to sending the outstanding account balance to the collection agency in an attempt to collect the debt. Accounts that are sent to the collection agency will be dismissed from the practice and only upon receipt of a signed "Release of Information" form will records be transferred to another provider or released to the parent/guardian.

Your prompt attention to notices from our office is key to our ability to continue to provide quality, comprehensive, and timely care to all of our patients. Your cooperation and adherence to this policy is greatly appreciated.

Signature (Parent/Legal Guardian): _____ **Date:**_____

PANTHER Pediatric Dentistry

Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1/2/2020, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities. At times dental students may shadow in our office as part of their training. We will ask you to complete a form giving permission if a student is present on your child's treatment day.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has

been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Official: Dr. Kari A. Cunningham
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