UNITY CARE NW's
MOBILE DENTAL PROGRAM

DENTAL SERVICES AVAILABLE

Dental Exam

Oral Health Instruction

Sealants

Fluoride

FREE TOOTHBRUSH & GOODY BAG

A written assessment of your child's oral health status and needs will be sent home after each visit.

THERE WILL BE **NO COST TO YOU!**

If your child is insured, Unity Care NW will bill their insurance.
You will not be billed for services that are not covered.
All services are provided for free.

COMMON QUESTIONS

Do I need to be there?
You are welcome to attend, but not required to.

What if I don't want my child to receive services?
To select which services you would like your child to receive, see the instructions on the Registration Form. If you do not want your child to receive any services, no action is required and you do not need to complete the form.

I have other children who are not enrolled in school. Can they be seen?
Yes! Contact the Dental Access Coordinator (below) to schedule.

OTHER QUESTIONS?

Contact **Robin Pearson**, Dental Access Coordinator:
(360) 788-2668 or ***robin.pearson@ucnw.org***

to REGISTER YOUR CHILD

Fill out the attached form completely and return it to their teacher or school office staff

NOTICE OF PRIVACY PRACTICES

Unity Care NW
Health Care for Everyone

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.

Unity Care NW respects your privacy and we understand that your personal health information is very sensitive. We will not use or disclose your information to others without your authorization, except as described in this Notice of Privacy Practices or required by law.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

Your Privacy Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your health record
You can ask to see or get an electronic or paper copy of your health record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 15 days of your request. We may charge a reasonable, cost-based fee. UCNW may waive this fee for patients who demonstrate financial need.

Ask us to send an electronic or paper copy of your health record to a third party
You can ask us to send an electronic or paper copy of your health record and other health information we have about you to another party, such as a doctor or an attorney. Ask us how to do this.

Ask us to correct your health record
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

We will make sure the person has this authority and can act for you before we take any action.

If you are under 18, you have the right to get certain services at Unity Care NW without parental involvement or consent. *

Sexually transmitted diseases (age 14+)

Birth control services (any age)

Mental health services (age 13+)

Substance abuse services (age 13+)

If you have any questions, we encourage you to talk to your health care provider.

*See Revised Code of Washington: RCW 70.24.110; RCW 9.02.100(1); RCW 71.34.530; RCW 70.96A.230

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting the Privacy Officer at the address at the end of this notice or by calling 360-788-2663.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting hhs.gov/hipaa/filing-a-complaint

We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation Include your information in a facility directory, if applicable

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes other than with insurance plans offering you information about coverage.
- Sale of your information Most sharing of mental health records, substance abuse records, and records related to sexually transmitted diseases.

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways:

Treat you
We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary. This may include phone calls and text messages to phone numbers you provide, emails, and mail through the US Postal Service. *Example: We use health information about you to manage your treatment and services, remind you about upcoming appointments, and offer you services related to your care at UCNW.*

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues
We can share health information about you for certain situations such as:

Preventing disease

Helping with product recalls

Reporting adverse reactions to medications

Reporting suspected abuse, neglect, or domestic violence

Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing.

If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site at UnityCareNW.org

CONTACT INFORMATION

Privacy Officer

Unity Care NW
1616 Cornwall Avenue, Suite 205
Bellingham, WA 98225

(360) 788-2663

MOBILE DENTAL PROGRAM REGISTRATION FORM

COMPLETELY FILL OUT BOTH SIDES of this form, **SIGN** it, and **RETURN** it to the school.

The Mobile Dental Program will make 2-3 visits during the school year.
This consent form applies to all visits this school year.

Please **CROSS OUT** any services you would **NOT** like your child to receive:

Visual Dental Exam	Oral Hygiene Instruction	Sealants	Fluoride Application

Questions? Call the Dental Access Coordinator at **360-788-2668**

CHILD'S PERSONAL INFORMATION

List all children enrolled in the School District that you would like to register:

Child's Name (First and Last)	**Sex**	**Date of Birth**	**Teacher/School**
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

Mailing Address **Homeless?** ☐ *If yes, check box*

Language preference: ☐ English ☐ Spanish ☐ Russian ☐ Punjabi

Street or PO Box

City WA State 98 Zip Code

Telephone Number

Email Address

CHILD'S MEDICAL AND DENTAL HISTORY

Does your child have any ongoing health problems? ☐ Yes ☐ No - *If yes, please describe and* ***include child's name:***

Child's Name — Health Problems

Does your child have any allergies? ☐ Yes ☐ No - *If yes, describe allergy, response and* ***include child's name:***

Child's Name — Allergies, Response

Is your child taking any medications? ☐ Yes ☐ No - *If yes, please list and* ***include child's name:***

Child's Name — Medications

Does your child see a dentist for an exam every 6 months? ☐ Yes ☐ No - *If yes, please list date and clinic:*

Approx. date of last exam — Dentist/Clinic Name

PLEASE COMPLETE AND SIGN BACK PAGE

Unity Care NW
Health Care for Everyone

CHILD'S INSURANCE INFORMATION

Is your child currently covered by WA APPLE HEALTH or MEDICAID? ❑ Yes ❑ No

Provider One # _____ You do not need to turn in a copy of your Provider One card.

Is your child currently covered by a Commercial Dental Insurance plan? ❑ Yes ❑ No

Dental Insurance Company (Delta Dental, Metlife, etc): _____

Policy # (Individual ID on card): _____ Group #:_____

Subscriber's Name: _____ Relationship to child: ❑ Parent ❑ Other

Subscriber's Social Security #: _____ /_____ /_____ **Subscriber's Date of Birth:** _____ /_____ /_____

Please turn in a copy of your dental insurance card with this form.

I authorized Unity Care NW or insurance company to release any information to process my claim

INFORMATION REQUIRED FOR GRANT PURPOSES

*Unity Care NW is a Non-Profit Health Center that receives financial support from government and private grants. This data is **required** for reporting.*

What is your child's ethnic background? (Select up to two) ❑ Hispanic ❑ Non-Hispanic ❑ I choose not to disclose

What is your child's race? (Select up to two) ❑ Asian ❑ Black/African American ❑ American Indian/Alaskan Native ❑ White ❑ Native Hawaiian ❑ Other Pacific Islander ❑ Another Race: _____ ❑ I choose not to disclose

Within the past 12 months, were you concerned your food would run out before you got money to buy more?
❑ Often true ❑ Sometimes true ❑ Never true ❑ Prefer not to disclose

Within the past 12 months, did you feel like the food you just bought didn't last and you didn't have money to get more?
❑ Often true ❑ Sometimes true ❑ Never true ❑ Prefer not to disclose

Family Size (Number of people in household): _____ **Monthly Income for Household** (Approximate): _____

*We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record to get more information about it by contacting our Health Information Management Specialists at (360) 676-6177 ext 1112. Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.*

SIGNATURE REQUIRED FOR SERVICES

To the best of my knowledge, all of the preceding answers are true and correct. By my signature below, I give consent for my child to receive the provided services unless otherwise specified and to have my insurance billed for the services provided. I permit the sharing of information with school personnel, as needed. I also acknowledge receipt of the attached Notice of Privacy Practices.

Parent/Guardian's Name: (Please Print) _____ **Parent's Date of Birth:** _____ /_____ /_____

Parent/Guardian's Signature: _____ **Date Signed:** _____ /_____ /_____

Relationship to Child: ❑ Mother ❑ Father ❑ Other: _____

Unity Care NW
Health Care for Everyone