VIOLA STARTZMAN CLINIC

MOBILE DENTAL CLINIC INFORMATION

December 17, 2021

Dear Wooster City School Parents,

The Viola Startzman Clinic is partnering with the High School to provide dental screenings and treatment to students in the High School during the school day. Dental care is very important to begin at a young age. We know, however, that it is often hard to find a dentist who accepts your insurance, or who has office hours that don't require you to miss work. We are happy to bring these programs to the High School to make care convenient for students and parents.

We will be hosting a mobile dental clinic on Friday January 21. During this clinic, children who are registered will receive a dental exam, a cleaning and fluoride varnish application. We may also perform dental x-rays if our dentist feels it is necessary to diagnose a problem or infection. If our dentist recommends other treatments, such as filling a cavity, we will contact the parent listed to get permission. If we get in touch with the parent, we will perform the needed treatment while we are there. If we can't get in touch with a parent or the treatment is more extensive, we will schedule a time to get the child to one of our dental clinics to complete the work.

While we cannot perform this service for free, we will work with every family to make sure every child gets the services they need. We will bill insurance (including all Medicaid Managed Care Plans). If you don't have insurance and cannot afford care, we have a very generous discounted fee structure that may allow your child to have care free of charge. If this is the case for you, please make sure you mark NO, I do not have dental insurance on page 2, and provide the name and phone number of a parent we can contact to help you apply for Financial Aid.

If you have any questions or concerns, please feel free to call our Dental Clinic at 330-262-2500 (extension 111).

Sincerely,

Jaime Parsons

Jaime Parsons
Executive Director

Section A: Patient Demographics:

VIOLA STARTZMAN CLINIC

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Child Name (First, Middle, Last)		
Date of Birth: _____/_____/_____ Month Date Year	Sex: ☐ Female ☐ Male	Social Security #:
Street Address:	City	State and Zip Code
Home Phone #	Cell Phone #	Preferred Language
Does the child identify as Hispanic? ☐ Yes ☐ No	Name of Primary Care Physician, if any	Name of Family Dentist, if any
Race: ☐ American Indian / Alaska Native ☐ Asian ☐ African American ☐ Caucasian ☐ Native Hawaiian/ Pacific Islander ☐ Multiracial ☐ Declined		
Emergency Contact Name:	Relationship to Patient	Emergency Contact Phone Number

Section B: ☐ YES, I have Dental Insurance

Insurance Information (Guarantor)

Insurance Holder's Name as it appears on the insurance card:	
Date of Birth of Insurance Holder: _____ / _____ / _____ Month Date Year	Social Security Number of Insurance Holder:
Insurance Plan Name:	Subscriber ID:
Group Name or Number:	
Insurance Company Address:	

Section C: ☐ NO, I do not have Dental Insurance

A Financial Counselor will be in contact with you to provide assistance in determining how to pay for your child's care. Please note that we cannot provide care until you make all necessary payment arrangements.

Please provide the following information on who we need to contact:

Name_____ Phone _____

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Patient Name:_____ Birthdate:_____

DENTAL VISIT HISTORY

Date of last dental visit	
Date of last dental xrays	
Are there any issues you want the dentist to be aware of today?	

ALLERGIES

Substance child is allergic to	Type of Reaction (What happens?)

CURRENT MEDICATIONS YOUR CHILD IS TAKING:

Name of Medication	Dose	Amount (#) Taken	Times per day

PREFERRED RETAIL PHARMACY

Name	Address	Phone Number

PAST MEDICAL HISTORY

Does child smoke cigarettes? ☐ Yes ☐ No	Does child smoke / use Vape products? ☐ Yes ☐ No	Does child chew or use snuff? ☐ Yes ☐ No
Does your child have a past history of any of the following? (check all that apply)		
☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Heart Surgery
☐ Diabetes	☐ Seizures	☐ Alcohol Abuse
☐ Heart Murmur / MVP	☐ Heart Attack	☐ Drug Abuse
☐ Joint Replacement	☐ HIV / AIDS	☐ Cancer
☐ Bleeding/Clotting disorder	☐ Hepatitis A, B or C	☐ Thyroid Issues
Could child be pregnant? ☐ Yes ☐ No		

PARENT / GUARDIAN SIGNATURE:_____ DATE:_____

PATIENT ACKNOWLEDGMENT AND CONSENT

On behalf of myself or my minor child or other patient named below, I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on Healthcare 2000 Community Clinic, Inc. DBA Viola Startzman Clinic (referred to as "VSC" in this form).

Consent to Health Care Services: I am requesting that health care services be provided to my minor child through the VSC, whether on-site at a VSC location, or at an off-site outreach event sponsored by the VSC. I voluntarily consent to all dental treatment and health care-related services that the caregivers at VSC consider to be necessary for the patient named below. These services may include diagnostic, therapeutic and imaging services. I am aware that the practice of dentistry is not an exact science; no guarantees have been made to me about the results of treatments or examinations. I understand that VSC may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

Financial Responsibility:
a. Subject to applicable law and the terms and conditions of any applicable contract between VSC and a third-party payer, and in consideration of all health care services rendered or about to be rendered to the below-named patient, I agree to be financially responsible and obligated to pay VSC for any balance not paid under the “Assignment of Benefits/ Third Party Payers” paragraph below.

Or, b. Subject to applicable law and the Viola Startzman Clinic Charitable Care Policy, and in consideration of all health care services rendered or about to be rendered to the below named patient, I agree to be financially responsible and obligated to pay VSC for the patient balances due.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to the below-named patient, I hereby assign to VSC all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding VSC’s regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by VSC to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third party payer.

Patient Rights and Responsibilities: I understand that I have the right to receive a copy of the VSC Patient Rights and Responsibilities at any time. Please request this by calling 330-262-2500 or in writing to Administrator, Viola Startzman Clinic, 1874 Cleveland Road Wooster, OH 44691.

Uses and Disclosures of Health Information: I understand that I can request a copy of the VSC's Notice of Privacy Practices. Please request this by calling 330-262-2500 or in writing to Administrator, Viola Startzman Clinic, 1874 Cleveland Road Wooster, OH 44691. The Notice of Privacy Practices explains how VSC may use and disclose confidential health information that identifies me (or the below-named patient). I consent to let VSC use and disclose health information about me (or the below-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the below-named patient’s) health information and financial account information to all third-party payers and/or their agents that are identified by VSC, its billing agents, consultants, and/or other agents that represent VSC or provide assistance to VSC for the purposes of securing payment from all parties who are potentially

liable for payment for my (or the below named patient's) health care, including for substance abuse, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that VSC has already relied on my consent.

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to VSC on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from VSC and its affiliates, clinical providers, and business associates, along with any billing services, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from VSC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

I hereby consent and grant to VSC the right and authority to photograph and/or record me, my image and voice, which could occur in connection with my diagnosis and treatment, and I agree that upon creation such images and/or recordings are owned by VSC. I understand that I have the right to request cessation of recording or filming at any time. I agree to release and forever discharge VSC, its agents, officers, volunteers and employees from any and all claims arising out of or in connection with the use of these images and/or recordings including, but not limited to, any claims for invasion of privacy, right to publicity or defamation.

By signing below, I am indicating that I have reviewed and acknowledge and consent to the terms described above.

In Person Consent

Signature of Patient or Responsible Party Date/Time

X_____ _____

Printed Name of Patient (or Responsible Party if not the Patient) Relationship to Patient

_____ _____

Phone Number(s) Home _____ Cellular _____

OR

Telephone Consent

Name of Individual Providing Telephone Consent Date/Time

_____ _____

Printed Name of Patient (or Responsible Party if not the Patient) Relationship to Patient

_____ _____

Phone Number(s) Home _____ Cellular _____

AUTHORIZATION FOR THE RELEASE OF DENTAL INFORMATION TO WOOSTER CITY SCHOOLS

Patient Name: _____ Date of Birth: _____ / _____ / _____

For the purposes of this form, "my," and "I" mean the patient listed above whose record is maintained by The Viola Startzman Clinic.

I hereby authorize The Viola Startzman Clinic to release any and all health information pertaining to dental care that is contained in my patient records to Wooster City Schools for treatment and as otherwise needed for my safety and education at the sole discretion of The Viola Startzman Clinic. Once my health care information is released, the information may be re-disclosed by the recipient and may no longer be protected by law. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I agree to this authorization. This authorization form will automatically expire when Viola Startzman Clinic is no longer providing school-based health care services to the students of Head Start Preschool, when I am no longer a student of Head Start, or when I revoke this authorization, whichever occurs first. I may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, through written notice sent to: Administrator, Viola Startzman Clinic: 1874 Cleveland Road Wooster, OH 44691

_____ _____ / _____ / _____

Signature of Patient/Patient's Personal Representative* (Student can sign if student is 18 or older)

Date Signed

_____ _____

Printed Name

Relationship, if not Patient

* If other than the patient's or parent's signature, a copy of legal paperwork verifying the patient's personal representative must accompany the request (i.e., court-appointed guardian of the person, durable power of attorney for health care).