



CONCERNING MEDICAID

For
Patient: _____

The process for Medicaid to approve the necessary dental treatment and to also fund for that treatment is a slow and confusing procedure. Essentially, Medicaid will make funds available to you to pay for all or a portion of the dental treatment for the patient once all the required documentation is approved. **Mobile Dental Care is *not* a Medicaid provider and is *not* paid directly by Medicaid.** Here is how it works:

- The nursing home resident, who is Medicaid approved, usually has a monthly income from their Social Security or retirement check. This is known as the resident's applied income.
- The applied income is paid to the nursing home for the resident's portion of their monthly room and board. This is the amount you pay the facility either monthly or through direct deposit.
- Once Medicaid approves dental treatment and funding for the resident, the caseworker will notify you by Form 4808 or 1259 that they are adjusting the resident's applied income to allow you to pay Mobile Dental Care for the dental services. Medicaid will pay the residents' room and board, in full, during this time period.
- This form will also instruct you, as the responsible party
 - to begin paying Mobile Dental Care each month;
 - how many months you will pay Mobile Dental Care;
- You will be responsible for paying Mobile Dental Care for the full amount of the dental treatment. These plans generally are completed within 4 to 6 months.
- Mobile Dental Care's fee structure and treatment planning conforms to Medicaid guidelines. However, Medicaid may not reimburse certain types of treatment. If the dentist feels your loved one requires treatment not covered by Medicaid, this will be discussed with you and payment arrangements will be made at that time.
- The Medicaid payment plan is valid only if the nursing home resident continues to live in a long-term care facility. Should the resident move from the facility prior to the completion of the Medicaid payment plan, you will be responsible for any remaining payments.
- By signing this form you agree as responsible party, that the contract to provide dental services is between you and Mobile Dental Care.
- By signing this form, you agree to reimburse Mobile Dental Care per the Medicaid documents and/or you authorize payment from Medicaid, otherwise payable to you, to be paid directly to Mobile Dental Care for services rendered.

By signing this form, I authorize the Texas Department of Human Services to release available information, all related financial documentation and responsible party name, address and phone number to Mobile Dental Care.

Signature of Responsible Party

Date



Mobile Dental Care

QUALITY ON-SITE DENTISTRY SINCE 1982

SARAH ALLEN, DDS
SYLVIA DE HOYOS, RDH, BS
ERIC FOX, RDH, BS
NICOLE FRIEDMAN, DDS
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WILLIAM MOORE, DDS
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KIMBERLY R. SELF, DDS
KEITH TEAGUE, DDS

ADVISE / CONSENT FORM FOR DENTAL CARE

Patient Name	Facility
Responsible Party	Relationship

I hereby authorize the doctor to perform any and all forms of treatment and/or therapy and to administer medication(s) that may be indicated in connection with the dental care of the above patient. I further authorize and consent that they employ such assistance as they deem fit.

Oral/teeth cleanings and restorative (fillings, crowns) dental work is needed for most patients and usually requires use of local anesthesia (Lidocaine, etc.) to block pain pathways. The risks involved in these procedures include:

1. Irritation and/or pain/swelling.
2. Disorientation, confusion, or prolonged drowsiness after treatment.
3. Pain, swelling, inflammation or infection of the area of the injection.
4. Injury to nerves or blood vessels in the area
5. An allergic or unexpected reaction. If severe, allergic reactions might cause more serious respiratory (lung) or cardiovascular (heart) problems, which may require treatment.
6. Nausea/vomiting and/or vomitus aspiration into the lungs.
7. Cardiovascular or respiratory responses which may lead to heart attack, stroke, or death.

In some cases, extraction of teeth is necessary. This is an irreversible process, and whether routine or difficult, it is a surgical procedure. As in any surgery, there are some possible hazards. These are, but are not limited to:

1. Swelling and/or bruising and discomfort in the surgery area.
2. Stretching of the corners of the mouth resulting in cracking and bruising.
3. Possible infection requiring further treatment.
4. Dry socket – pain from the surgical site due to loss of the blood clot. (This is much more common with lower teeth extractions.) Dry socket generally requires additional care.
5. Possible damage to adjacent teeth, especially those with large fillings or crowns.
6. Possible numbness or altered sensation in the teeth, lip, tongue, and chin due to the closeness of teeth roots to the nerves which can be bruised and/or injured. Sensation most often returns to normal; but in rare cases, the loss may be permanent.
7. Trismus – Limited jaw opening due to inflammation and/or swelling. Sometimes it is due to jaw joint discomfort (TMJ) especially when TMJ problems previously exist.
8. Bleeding – significant bleeding is not common, but persistent drainage from the extraction location can be expected for several hours.
9. Sharp ridges or bone splinters may form later at the edge of the socket. These ridges or bone splinters may require additional surgery to smooth or remove.
10. Incomplete removal of tooth fragments – sometimes small root tips may be left in place to avoid injury to vital structures such as the nerves and sinus. Sinus cavity involvement: The roots of upper back teeth are often close to the sinus cavity. Occasionally, a piece of the root can be displaced into the sinus cavity or an opening may occur into the mouth that may require additional care.
11. Jaw fracture – While quite rare, it is possible in difficult or deeply impacted teeth.

Most procedures are routine and serious complications are not expected. Those that do occur are most often minor and can be treated. I recognize there can be no warranty as to the outcome of treatment.

Signature of Responsible Party

Date



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CONSENT FOR ANESTHESIA AND PRE-MEDICATION

Patient's Name

Date

I am the responsible party for the above listed patient, and I understand that the dentist has determined it is necessary that the patient have oral premedication for sedation prior to their dental procedure and that local anesthesia might also be used.

MEDICATIONS:

1. LOCAL ANESTHESIA: (Novocaine, Lidocaine, etc.) is given to block pain pathways in a localized area.
2. ORAL PREMEDICATION: Involves a pill being taken for relaxation prior to giving local anesthesia and/or treatment.

I further understand whichever technique(s) used, the administration of any medication involves certain risks. These include:

1. Nausea and vomiting.
2. An allergic or unexpected reaction. If severe, allergic reactions might cause more serious respiratory (lung) or cardiovascular (heart) problems, which may require treatment.
3. Pain, swelling, inflammation or infection of the area of the injection.
4. Injury to nerves or blood vessels in the area.
5. Disorientation, confusion or prolonged drowsiness after surgery, which could lead to falls.
6. Cardiovascular or respiratory responses, which may lead to heart attack, stroke or death.

Fortunately, these complications and side effects are not common and that well-monitored anesthesia/sedation is generally very safe, comfortable, and well-tolerated.

Finally, I advise I have had ample opportunity to ask questions and am now giving my advised consent to the dentist to follow through with the aforementioned treatments.

CONSENT

I understand that no guarantee can be promised and I give my free and voluntary consent for treatment. My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved in the proposed surgery, anesthesia, and premedication. I certify that I speak, read, and write English.

Patient's (or Legal Guardian's) Signature

Date



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MOBILE DENTAL CARE / SENIOR DENTAL CARE

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.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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



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Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$25.00 for the first (20) pages and 15 cents for each page thereafter and a reasonable fee for actual cost of mailing shipping or delivery to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Confidential Communications: You have the right to receive confidential communications of protected health information.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: Clark Petersen

Telephone: (214) 750-6860 x7102

Fax: (214) 265-0066

E-mail: clark@mobiledentalcare.com

Address: 10830 N. Central Expwy., Suite 495, Dallas, TX 75231

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2003).



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**Mobile Dental Care / Senior Dental Care
 ACKNOWLEDGEMENT OF RECEIPT OF
 NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

 {Please Print Name}

 {Signature}

 {Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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Mobile Dental Care / Senior Dental Care

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Clark Petersen

Telephone: (214) 750-6860 x7102 Fax: (214) 265-0066

E-mail: clark@mobiledentalcare.com

Address: 10830 N. Central Expwy, Suite 495, Dallas, TX 75231

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____