Dental Hygiene Informed Consent

Maureen Kaye, RDHAP **Denise Cozza, RDHAP**

I understand that DC/MK Mobile Dental Hygiene Care will perform the following services:

* Oral Evaluation/Oral Cancer Screening
* Teeth Cleaning (scaling and polishing/periodontal maintenance)
* Fluoride Varnish Application

Recommendation: I understand having my teeth cleaned every three months (ninety-one days) will help to further reduce any deterioration of my teeth and gums, and help to promote my overall health.

I understand that the Registered Dental Hygienist In Alternative Practice (RDHAP) can not diagnose any pathology. In the event of a possible abnormality, the RDHAP will recommend to the facility a referral to a dentist and/or physician.

Dentures: I understand that I wear full dentures (no teeth) that an oral evaluation is recommended to check for tissue abnormalities; lesions, swollen glands and an oral cancer screening.

Type of Billing (other than Medi-Cal) _____

In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information that describes how we may use and disclose your protected health information to carry out treatment, payment of health care operation and for other purposes that are permitted or required by law.

We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example: your health dental information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information periodically to another dentist, physician or health care provider who becomes involved in your care.

We may use and disclose dental information about you in order to obtain payment for services rendered. Such disclosures may be made to you, an insurance company, responsible party or third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

Permission granted for review of medical records.
An associate RDHAP may be the provider of mobile dental hygiene services.
Permission granted to take pictures of patient for chart identification and educational purposes.

I have read, understood, and agreed to the above. I agree that a photocopy of this authorization shall be as valid and effective as the original forever. I am legal age, and legally competent to make this assignment.

Client Name: _____

Signature of Client: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____