BRIDGING Brighter Smiles

Brightening Smiles at Royall Schools!

WHO?

Students 7th-12th Grade!!

WHERE?

Right At Your School!

WHEN?

During The School Day!

WHAT?

- Oral Screening
- Dental Sealants
- Oral Health Education
- Silver Diamine Fluoride
- Fluoride Varnish
- Dental Cleaning
- Referral Assistance

HOW?

Return Form To Your School Office or ENROLL ONLINE: enrollment.bbsmiles.org

***Don't forget to enroll your Middle and High Schoolers!**

AND…

Forward Health (Badger Care) Accepted!

We do not bill/accept other private dental insurance

Charitable care is offered for those students who do not have the financial resources to access dental care.

SIGN UP NOW! DENTAL CARE RIGHT AT SCHOOL!
enrollment.bbsmiles.org

Bridging Brighter Smiles Enrollment Form

Questions? Please feel free to call (262) 896-9891

Scan and email forms to enrollment@bbsmiles.org or Fax forms to (262) 347-4449

DUE April 13th

Name of School: _____

Student Enrollment

☐ **Yes, please enroll my dependent.**

First Name:_____ **Last:**_____ **Middle:**_____

Date of Birth:_____ **Sex:** ☐ **Male** ☐ **Female**

Type of Dental Insurance: ☐ **BadgerCare/Forward Health** ☐ **No Insurance** ☐ **Other**

Parent/Guardian First Name:_____ **Last:**_____

Primary/Day Phone:_____ **E-mail:**_____

Address:_____

City/State/Zip:_____

Student Health History

If yes please explain, be specific.

Does your dependent have any allergies? (Bridging Brighter Smiles is Latex Free):_____ ☐ YES ☐ NO

_____

Has your dependent been diagnosed with a physical or mental disability?_____ ☐ YES ☐ NO

_____

Does your dependent require an antibiotic prior to dental procedures? (i.e. due to a heart condition) ☐ YES ☐ NO

_____

Does your dependent use medicine prescribed by a doctor?_____ ☐ YES ☐ NO

_____

Authorization

I understand that by signing this form, initial and ongoing preventative oral care treatment will be provided for my dependent. This consent is good for two school years. I have the ability to dis-enroll at any time by written withdrawal of consent. I authorize BadgerCare/Medicaid insurance payments for services rendered to Bridging Brighter Smiles, Inc. and agree to pay any BadgerCare/Medicaid copays. If my dependent is not insured through BadgerCare/Medicaid insurance, I agree to pay the attached standard fees for services rendered.

Parent/Guardian Signature:_____ **Date:**_____

Initial Here

☐

I acknowledge that I have received or have been offered a copy of Bridging Brighter Smiles, Inc.'s Notice of Privacy Practices. I understand that I may get a copy of the Notice of Privacy Practices by visiting the Bridging Brighter Smiles, Inc.'s website at http://bridgingbrightersmiles.org/forms/, or from contacting the visit coordinator at any school location Bridging Brighter Smiles, Inc. provides care.

It is still strongly recommended that you seek out a dental home (family dentist) for routine dental care including any follow up care which may be recommended by this school based oral health program.

NOTICE OF PRIVACY PRACTICES

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

Effective Date: June 18, 2018

PURPOSE

Bridging Brighter Smiles, Inc. ("Bridging Brighter Smiles") is required by law to maintain the privacy of your health information in accordance with federal and state law. This Notice of Privacy Practices ("Notice") outlines our legal duties and privacy practices with respect to health information. We are required by law to provide you with a copy of this Notice and to notify you following a breach of your unsecured health information.

We will abide by the terms of this Notice. We reserve the right to make changes to this Notice as permitted by law. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. Each version of the Notice will have an effective date listed on the first page. If we change this Notice, you can access the revised Notice on our website (http://bridgingbrightersmiles.org/forms/) or from contacting the visit coordinator at any school location Bridging Brighter Smiles provides care.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following categories describe the ways that we may use and disclose your health information without your written authorization.

Treatment. We may use and disclose your health information to provide you with medical treatment and services. For example, your health information may be disclosed to physicians, nurses (including school nurses), or other health care providers who are involved in your care so that they may coordinate or manage your health care services or to facilitate consultations or referrals as part of your treatment.

Payment. We may use and disclose your health information to obtain payment for the services we provide to you. For example, we may disclose your health information to seek payment from Wisconsin's Forward Health (BadgerCare) program.

Health Care Operations. We may use and disclose your health information to conduct certain of our business activities, which are called health care operations. These uses and disclosures are necessary to run our business and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, general administrative activities, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as billing and IT services. In these cases, we will enter into a written agreement with the business associates to ensure they protect the privacy of your health information.

Family Members and Friends for Care and Payment and Notification. If you verbally agree to the use or disclosure and in certain other situations, we may make the following uses and disclosures of your health information. We may disclose certain health information to your family, friends, and anyone else whom you identify as involved in your health care or who helps pay for your care; the health information we disclose would be limited to the health information that is relevant to that person's involvement in your care or payment for your care. We may use or disclose your information to notify or assist in notifying a family member, personal representative, or any other person responsible for your care regarding your location, general condition, or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status, and location.

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

Public Health Reporting. We may disclose your health information to public health agencies as authorized by law. For example, we may report certain communicable diseases to the state's public health department.

Reporting Victims of Abuse or Neglect. We may disclose health information to the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence. We only make this disclosure if you agree or when we are required or authorized by law to make the disclosure.

Health Care Oversight. We may disclose your health information to authorities and agencies for oversight activities allowed by law, including audits, investigations, inspections, licensure and disciplinary actions, or civil, administrative, and criminal proceedings, as necessary for oversight of the health care system, government programs, and civil rights laws.

Legal Proceedings. We may disclose your health information pursuant to a court order if you are involved in a legal proceeding. Under most circumstances when the request is made through a valid subpoena, a discovery request, or involves another type of administrative order, your authorization will be obtained before disclosure is permitted.

Law Enforcement. We may disclose your health information to a law enforcement official for certain specific purposes, such as reporting certain types of injuries.

Research. Under certain circumstances, we may disclose your health information to researchers who are conducting a specific research project. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve use and disclosures of your health information without your authorization.

To Avert a Serious Threat to Health or Safety. If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information in a very limited manner to someone able to help lessen the threat.

Please be aware that state and other federal laws may have additional requirements that we must follow or may be more restrictive than HIPAA on how we use and disclose your health information. If there are specific more restrictive requirements, even for some of the purposes listed above, we may not disclose your health information without your written permission as required by such laws. For example, we may be required by law to obtain your written permission to use and disclose your information related to treatment for a mental illness, developmental disability, or alcohol or drug abuse.

Other Uses and Disclosures

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. Some examples include:

- Marketing: We will not use or disclose your health information for marketing purposes without your written authorization except as otherwise permitted by law.
- Sale of Your Health Information: We will not sell your health information without your written authorization except as otherwise permitted by law.

If you change your mind after authorizing a use or disclosure of your health information, you may withdraw your permission by revoking the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of your health information that occurred before you notified us of your decision, or any actions that we have taken based upon your authorization. To revoke an authorization, you must notify us in writing at Bridging Brighter Smiles, Attention: Privacy Officer, 711 West Moreland Blvd, Suite 204, Waukesha, WI 53188.

Your Rights Regarding Your Health Information

This section describes your rights regarding the health information we maintain about you. All requests or communications to us to exercise your rights discussed below must be submitted **in writing** to Bridging Brighter Smiles, Attention: Privacy Officer, 711 West Moreland Blvd, Suite 204, Waukesha, WI 53188.

Right to Request Restrictions. You have the right to request restrictions on how your health information is used or disclosed for treatment, payment, or health care operations activities. However, we are not required to agree to your requested restriction, unless that restriction is regarding disclosure of health information to your health insurance company and: (1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (2) the health information pertains solely to a health care item or service for which you or another person (other than your health insurance company) paid for in full. If we agree to your requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate your health information to you in a certain manner or at a certain location. For example, you may wish to receive information about your health status through a written letter sent to a private address. We will grant reasonable requests. We will not ask you the reason for your request.

Right to Inspect and Copy. You have the right to inspect and receive a copy of your health information. We may charge you a fee as authorized by law to meet your request. You may request access to your health information in a certain electronic form and format, if readily producible, or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit such a copy to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. You have a right to request that we amend or correct your health information that you believe is incorrect or incomplete. For example, if your date of birth is incorrect, you may request that the information be corrected. To request a correction or amendment to your health information, you must make your request in writing and provide a reason for your request. You have the right to request an amendment for as long as the information is kept by or for us. Under certain circumstances we may deny your request. If your request is denied, we will provide you with information about our denial and how you can file a written statement of disagreement with us that will become part of your medical record.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you. Your request must state a time period which may not go back further than six years. You will not be charged for this accounting, unless you request more than one accounting per year, in which case we may charge you a reasonable cost-based fee for providing the additional accounting(s). We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice. You have the right to receive a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. A paper copy of this Notice can be obtained from the visit coordinator at any school location Bridging Brighter Smiles provides care and is also available at our website at http://bridgingbrightersmiles.org/forms/.

Complaints

You have the right to file a complaint if you believe your privacy rights have been violated. If you would like to file a complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Bridging Brighter Smiles, Attention: Privacy Officer, 711 West Moreland Blvd, Suite 204, Waukesha, WI 53188 or by contacting our Privacy Officer at 262-896-9891. You also have the right to complain to the Secretary of the United States Department of Health and Human Services. **You will not be penalized or otherwise retaliated against for filing a complaint.**

Contact Information

If you have questions or concerns about your privacy rights, or the information contained in this Notice, please contact the Bridging Bright Smiles Privacy Officer at 262-896-9891