Tracy Weldon RDH PHDH
PUBLIC HEALTH DENTAL HYGIENIST
508-612-7006 tweldon@vdaofma.com

SCHOOL YEAR _____

Patient Consent – HIGASHI DENTAL HYGIENE PROGRAM By signing this consent, you permit the dental professional associated with this program to perform necessary diagnostic procedures including an oral screening and/or dental hygiene exam. You may also agree to treatment that may be necessary for dental and overall health such as but not limited to; dental cleaning, toothbrushing, polish, fluoride applications including Silver Diamide Fluoride which may cause black stain on decayed surfaces in order to arrest the process of decay. You also understand that additional treatment may be necessary in which case you will be referred to seek a dentist for follow-up care.

I understand that **Tracy Weldon** RDH (Dental Provider) will consult with Higashi pertaining to my child's health and medical needs as it may impact their health and dental care. This information can be used for the purpose of providing treatment, obtaining payment or determining dental insurance benefits.

I have read and understand the services that may be provided to my child by the Dental Provider, and I consent for my child to participate. I understand that my child should obtain a dental examination by a licensed dentist at least once a year.

A written summary of the examination and services is given to Higashi each visit and is available upon request.

PLEASE CHECK SERVICES THAT YOU WOULD LIKE YOUR CHILD TO PARTICIPATE IN:

_____ **DENTAL CLEANING, DENTAL HYGIENE EXAM, FLUORIDE TREATMENT**

_____ **TWICE** PER SCHOOL YEAR _____ **ONCE** PER SCHOOL YEAR **CHOOSE ONE**:

FALL AND SPRING ☐ **FALL** ☐ **OR** **SPRING** ☐

_____ OTHER (Please note) _____

CHILDS NAME_____DATE OF BIRTH_____

I UNDERSTAND THAT THE DENTAL PROVIDER IS UNABLE TO PROVIDE SERVICES WITHOUT SIGNED CONSENT FORM.

PARENT/GUARDIAN SIGNATURE_____DATE: _____

EMAIL ADDRESS: _____

MassHealth and other dental insurances are accepted. (Most insurance cover 2 cleanings per CALENDAR year)

INSURANCE TYPE _____POLICY NUMBER_____

_____NO INSURANCE (**PRIVATE PAY FEE FOR CLEANING, DENTAL HYGIENE EXAM AND FLUORIDE TREATMENT $75**)

CHECK FOR $75 to TRACY WELDON, or credit card accepted

CREDIT CARD NUMBER ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

EXPIRATION _____/_____ 3 DIGIT CODE _____ _____ _____ ZIPCODE ____ ____ ____ ____ ____

NAME ON CREDIT CARD _____SIGNATURE: _____

BILLING ADDRESS: _____

VDA of MA

Visiting Dental Associates of Massachusetts

888-236-3536
info@VDAofMA.com

the RIGHT people… doing the RIGHT things… for the RIGHT reasons

Who We Are

A distinguished group of dental healthcare providers who deeply believe that oral healthcare should be accessible to everyone.

Public Health Dental Hygienists with the knowledge and passion to provide everyone with excellent state-of-the-art preventive oral health services.

Good oral care is very important. Tooth decay is the number one health disease and can be painful and dangerous... an undiagnosed abscess can cause infection of your bloodstream and possibly lead to death.

Gum disease can make diabetes and cardiovascular problems worse. It can cause an increase in lung infections. Untreated gum disease leads to tooth loss making eating difficult and painful; creates self-esteem issues; and impacts the quality of life.

We come to you and provide these services in your locations so that you are more comfortable and have the amount of time you need and deserve. The same hygienist visits your location with portable dental equipment each time.

We get to know you and your family!

Nursing Homes, Assisted Living Facilities, Group Homes, Doctor's Offices… Our experienced staff is willing to work WITH you to choose options that give your clients the best service available!

Our Services Include…

- ✔Dental Cleanings
- ✔Dental X-Rays
- ✔Dental Screenings
- ✔Fluoride Treatments
- ✔Oral Cancer Screenings
- ✔Dental Sealants
- ✔Individualized Oral Hygiene Instruction and Referrals

Visiting Dental Associates of MA LLC

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. This notice applies to all staff covered under this program

Patient Privacy Pledge
The privacy of the individual participating in this program is a priority. We understand that health information is personal and we are committed to protecting their health information. We will follow strict federal/state guidelines to maintain the confidentiality of all health information and will follow the terms of this notice.

Our Responsibilities
It is our responsibility to:

- Ensure that identifying health information about you is kept private.
- Provide Notice of our legal duties and privacy practices with respect to health information.
- Communicate any changes made to our current privacy practices.

Use and Disclosure of Health Information
Your health information may be used as follows:

- Documented treatment services may be shared with other healthcare providers involved in meeting oral health needs.
- To communicate with family members involved in meeting oral health care needs
- To conduct normal business practices and management of the dental program
- To provide payment/billing information about services provided to third parties in order to receive payment
- To communicate appointment reminders by telephone, mail or email

There are limited times when we are permitted or required to disclose health information without your signed permission. These situations could include but are not limited to:

- For Public Health activities such as tracking diseases or medical data
- To protect victims of abuse or neglect
- For federal/state health oversight activities such as fraud investigations. When required to do so by Federal, State or local law.

Other use and disclosures previously described may only be done with your signed authorization. You may revoke your authorization in writing at any time.

Your Rights
You have the right to:
- Request that we restrict how we use or disclose your health information
- Request use of specific telephone number address or email to communicate with you.
- Inspect and copy your health information (fees may apply)
- Receive an accounting of how your health information was disclosed
- Obtain a paper or electronic copy of this notice
- Register a complaint : See *File a Complaint*, below.

File a Complaint
If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services: Office of Civil rights, United States Department of Health and Human Services, Government Center JFK Federal Building 1875, Boston MA 02203 (617) 565-1348.
No action may be taken against you for filing a complaint.

How to Contact Us
If you have question or would like further information about this notice, please contact;
Visiting Dental Associates Of MA, LLC
info@VDAOFMA.com
Cathy Grinham, RDH: 508-813-6034