Bridging Brighter Smiles Enrollment Form

Questions? Please feel free to call (262) 896-9891
Scan and email forms to office@bbsmiles.org or Fax forms to (262) 347-4449

Name of School: _____

Student Enrollment

Edgar

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

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

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

Race: (Optional) ☐ **White** ☐ **Hispanic** ☐ **Black** ☐ **Asian** ☐ **Native American** **Other:**_____

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 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 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 have received the enclosed Notice of Privacy Practices and Coverage Information, and I have been provided an opportunity to review it.

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.

Coverage Information

We Accept the Forward Health (BadgerCare) Card!

Initial and ongoing preventative oral care treatment is covered for students with an active Forward Health (BadgerCare) Card.

No Forward Health (BadgerCare) Card

Standard Fees

Oral Screening	$15.00
Cleaning	$32.00
Fluoride Application	$18.00
Sealants	$25.00/Tooth

*Fees are subject to change without notice.

For private or no dental insurance participants your dependent will receive a screening, cleaning, and fluoride varnish application on average every 6 months. Please notify us if you would prefer services one time per school year only. Prior to sealant placement you will be contacted by the Bridging Brighter Smiles coordinator for prior authorization.

Questions? Call (262) 896-9891

www.bridgingbrightersmiles.org

Bridging Brighter Smiles - Confidentiality Notice

This notice describes how medical and drug and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

GENERAL INFORMATION:
Information about your treatment and care, including payment for care, is protected by two federal laws -

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Confidentiality Law. Under these laws the program may not say to a person outside of the program that you attend the program, nor may the program disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by the federal laws referenced below.

The program must obtain your written consent before it can disclose information about you for payment purposes. For example, the program must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before the program can share information for treatment purposes or for health care operation. However, federal law permits the program to disclose information in the following circumstances without your written permission:

To program staff for purposed of providing treatment and maintaining the clinical record;
Pursuant to an agreement with a business associate (e.g. clinical laboratories, pharmacy, record storage services, billing services);
For research, audit or evaluations (e.g. State licensing review, accreditation, program data reporting as required by the State and/or Federal government);
To report a crime committed on the program's premises or against program personnel;
To medical personnel in a medical/psychiatric emergency;
To appropriate authorities to report suspected child abuse or neglect;
To report certain infectious illnesses as required by state law;
As allowed by a court order.

Before the program can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing. (NOTE: Revoking consent to disclose information to a court, probation department, parole office, etc may violate an agreement that you have with that organization. Such a violation may result in legal consequences for you.)

CONFIDENTIALITY NOTICE, YOUR RIGHTS:
Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health and treatment information. The program is not required to agree to any restrictions that you request, but if it does agree with them, it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.
You have the right to request that we communicate with you by alternative means or at an alternative location (e.g. another address). The program will accommodate which requests that are reasonable and will not request an explanation from you.
Under HIPAA you also have the right to inspect and copy your own health and treatment information maintained by the program, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.
Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in the program's records, and to request and receive an accounting of disclosures of your health related information made by the program during the six (6) years prior to your request.
If your request to any of the above is denied, you have the right to request a review of the denial by the program Administrator.
To make any of the above requests, you must fill out the appropriate form that will be provided by the program.

THE USE OF YOUR INFORMATION AT THE PROGRAM:
In order to provide you with the best care, the program will se your health and treatment information in the following ways:
Communication among program staff (including students or other interns) for the purposes of treatment needs, treatment planning, progress reporting and review, staff supervision, incident reporting, medication administration, billing operations, medical record maintenance, discharge planning, and other treatment related processes.
Communication with Business Associates such as clinical laboratories, food service , agencies that provide on -site services, and long term record storage.

THE PROGRAM'S DUTIES:
The program is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. The program is required by law to abide by the terms of this notice. The program reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. The program will provide current patients with an updated notice, and will provide affected former patients with new notices when substantive changes are made in the notice.