UAMS Oral Health Clinic Patient Registration Form

(Please Print)

Patient Information:

Name____ **Male** or **Female**
First Middle Last

Date of birth ______________ **SSN** ________________ **Referred by** ______________

Address ____

City__________________ **State** ________ **Zip Code**______________

Home #________**Work #**________**Cell #** ________**Email**______________

Employer__________________ **Address**______________________

Responsible Party Information:

Spouse's/Parent's Name (circle one) ______________________________

Date of birth__________ **SSN**____________ ☐ **Responsible party is policy holder for patient**

Employer______________________________**Phone Number**__________

Nearest relative not living with you______________________________

Relationship__________________ **Phone Number** __________________

EMERGENCY CONTACT ______________________________________

Phone Number __________________ **Relationship** __________________

Insurance Information:

Primary Dental Insurance Company______________________________

Address__________________________ **Phone Number**______________

Policy Holder ______________ **Date of birth**__________ **Group #** __________

Employer ______________________ **ID #** ______________________

Secondary Dental Insurance Company ____________________________

Address __________________________**Phone Number**______________

Policy Holder ______________ **Date of birth**__________ **Group #** __________

Employer ______________________ **ID #** ______________________

MEDICAL HISTORY

PATIENT NAME ____ Birth Date ___________________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ________________________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ________________________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ________________________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ________________________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ________________________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ________________________________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ________________________________

Do you have, or have you had, any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	◯	◯	Cortisone Medicine	◯	◯	Hemophilia	◯	◯	Radiation Treatments	◯	◯
Alzheimer's Disease	◯	◯	Diabetes	◯	◯	Hepatitis A	◯	◯	Recent Weight Loss	◯	◯
Anaphylaxis	◯	◯	Drug Addiction	◯	◯	Hepatitis B or C	◯	◯	Renal Dialysis	◯	◯
Anemia	◯	◯	Easily Winded	◯	◯	Herpes	◯	◯	Rheumatic Fever	◯	◯
Angina	◯	◯	Emphysema	◯	◯	High Blood Pressure	◯	◯	Rheumatism	◯	◯
Arthritis/Gout	◯	◯	Epilepsy or Seizures	◯	◯	High Cholesterol	◯	◯	Scarlet Fever	◯	◯
Artificial Heart Valve	◯	◯	Excessive Bleeding	◯	◯	Hives or Rash	◯	◯	Shingles	◯	◯
Artificial Joint	◯	◯	Excessive Thirst	◯	◯	Hypoglycemia	◯	◯	Sickle Cell Disease	◯	◯
Asthma	◯	◯	Fainting Spells/Dizziness	◯	◯	Irregular Heartbeat	◯	◯	Sinus Trouble	◯	◯
Blood Disease	◯	◯	Frequent Cough	◯	◯	Kidney Problems	◯	◯	Spina Bifida	◯	◯
Blood Transfusion	◯	◯	Frequent Diarrhea	◯	◯	Leukemia	◯	◯	Stomach/Intestinal Disease	◯	◯
Breathing Problem	◯	◯	Frequent Headaches	◯	◯	Liver Disease	◯	◯	Stroke	◯	◯
Bruise Easily	◯	◯	Genital Herpes	◯	◯	Low Blood Pressure	◯	◯	Swelling of Limbs	◯	◯
Cancer	◯	◯	Glaucoma	◯	◯	Lung Disease	◯	◯	Thyroid Disease	◯	◯
Chemotherapy	◯	◯	Hay Fever	◯	◯	Mitral Valve Prolapse	◯	◯	Tonsillitis	◯	◯
Chest Pains	◯	◯	Heart Attack/Failure	◯	◯	Osteoporosis	◯	◯	Tuberculosis	◯	◯
Cold Sores/Fever Blisters	◯	◯	Heart Murmur	◯	◯	Pain in Jaw Joints	◯	◯	Tumors or Growths	◯	◯
Congenital Heart Disorder	◯	◯	Heart Pacemaker	◯	◯	Parathyroid Disease	◯	◯	Ulcers	◯	◯
Convulsions	◯	◯	Heart Trouble/Disease	◯	◯	Psychiatric Care	◯	◯	Venereal Disease	◯	◯
									Yellow Jaundice	◯	◯

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ________________________________

Comments: ________________________________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ________________________________ DATE ____________________

Delta Dental Foundation of Arkansas Oral Health Clinic at UAMS

Clinical Policies and Patient Rights

The UAMS Oral Health Clinic is part of the College of Health Profession's Center for Dental Education. The OHC is a General Dentistry Practice designed to provide clinical education and experience to student and residency programs. Because teaching and education is a primary responsibility of this clinic, our operations differ somewhat from the typical private dental practice. Please take the opportunity to review this "Clinical Policies and Patient Rights" statement. You will be asked to sign a separate consent form indicating your willingness to proceed. We are grateful that you have chosen UAMS for your dental needs, and we appreciate your patience and cooperation with the uniform application of these policies.

New Patients

The UAMS Oral Health Clinic welcomes all new patients. The OHC does not discriminate on the basis of age, sex, race, or handicapping condition. Should you require special care due to a hardship, please inform our staff. In the interest of providing comprehensive care to our patients, the OHC will provide all new patients over the age of 18 years with an initial appointment for a comprehensive evaluation to include medical history review, extra/intra-oral examination, appropriate radiograph(s) as determined by the individual's needs, individualized patient education including oral hygiene instructions, and diagnosis. After the comprehensive evaluation, you will be informed on your oral health status and your subsequent treatment needs. All treatment will be rendered under the supervising dentist and will meet the highest standards recognized by the dental and dental hygiene profession. We ask that you arrive 20 minutes prior to the start of your first dental appointment to allow completion of patient registration and medical history forms. Please bring your driver's license or another form of photo ID along with your dental insurance card (if insured).

Children and Minors Under 18

All minors must have the medical history and consent for treatment signed by a parent or guardian prior to treatment. No children are allowed in the clinic operatories areas unless being treated as a patient. Our clinic is not equipped to provide child care or babysitting services. Please make arrangements to have your children properly supervised when you are receiving treatment.

X-Rays

X-rays (dental radiographs) are a necessary part of your diagnosis and treatment. Current radiographs are required of all patients. The type of radiographs prescribed by the dentist will be based upon your individual needs. Refusal to have radiographs taken or to provide current radiographs from your previous dentist's office may prevent us from accurately assessing your dental condition and could result in the inability to render certain dental treatments. Previous radiographs can be mailed to us or transferred to us electronically by your previous dentist once you provide consent to release information. If these images are not of diagnostic quality, a repeat may be needed. You are responsible for arranging the dental record transfer prior to your first scheduled appointment in the OHC. Upon your request, an electronic duplicate of any pertinent radiographs on file with the OHC will be sent to a private dentist or other institution for a $15.00 duplication fee.

Infection Control

For your protection, all dental instruments are sterilized and dental units are disinfected after each patient. Students, residents, and faculty are required to wear masks, gloves, and glasses during patient treatment. The OHC maintains the infection control guidelines set forth by the Centers for Disease Control and Prevention (CDCP) and the Occupational Safety and Health Administration (OSHA).

Appointment Keeping

We request your cooperation in appearing on time for your scheduled appointments. Depending on the individual needs, several appointments may be necessary to complete treatment. If you are unable to keep your previously arranged appointment time, please provide 24 hours' notice to our receptionist. If you do not appear for a previously arranged appointment it will be considered a *broken appointment.* Three broken appointments will result in your dismissal as a patient in the clinic.
Patients are to park in the UAMS Patient and Visitor parking decks.

Payments

Payment of services is due at the time treatment is provided. Payment must be made in full by cash, check, or credit card. UAMS financial policy does not allow for payment plans or extension of credit. You will be given a receipt for services and fees at the conclusion of each dental visit. If you have dental insurance, you will be given an *estimated* cost for the treatment rendered. You are financially responsible for any and all remaining fees that your insurance plan does not cover.

Dental Insurance

The OHC will file dental insurance claims as a courtesy to our patients. We will attempt to answer any questions relating to your dental insurance plan when you contact us; however, understand that you are the financially responsible party for any charges not covered by your insurance. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. To meet our contractual agreements with certain dental plans, you will be asked below to assign your benefits to the OHC which will permit us to only collect deductibles and co-payments at the time of service. Please remember to promptly notify the clinic to update your insurance records whenever plan coverage changes.

Cellular Phones

Students are not allowed to use cellular devices in order to focus on your treatment. Therefore, we ask that you return the same courtesy to our students and the supervising faculty by refraining from making or receiving phone calls or text messages while in the treatment areas. Each cell phone should be turned **OFF** or placed on **MUTE** while receiving dental treatment.

Photography and Video

Photography and video is frequently employed to assist in the diagnosis of certain dental conditions. The gathering of diagnostic images is considered a part of your general consent for treatment. However, certain clinical situations may present the opportunity to document procedures for purposes of education, including publications in professional journals or books. A separate authorization to take and release patient photographs and video/audio recordings will be presented for your signature in the event that teaching materials are being gathered. If you sign this special consent form, all photographs, recordings, video, or drawings will remain the sole property of the UAMS Oral Health Clinic and may be used by members of the faculty or released to the public for commercial purposes.

Medical History

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. To ensure that appropriate precautions are taken according to each person's physical status as determined by medical history, physician's recommendations, and/or risk factors, each patient must have a completed medical history form. It is the responsibility of the patient to provide accurate and up-to-date information at each dental appointment, including a complete medication list with current dosing. Dental procedures will not be initiated until there are no unresolved questions remaining in the medical history. Inadequate or inaccurate information can be dangerous to your health.

General Consent for Treatment

By signing the UAMS "General Consent for Treatment" form, you are making formal application to the University of Arkansas for Medical Sciences Oral Health Clinic for admission to their patient health care system. Your signature also acknowledges that you have received a copy of the UAMS "Notice of Privacy Practices" and this "Clinic Policies and Patient Rights" statement. Your signature will give us general permission to complete various indicated dental treatments (including local, oral, and inhalation anesthetics along with surgical dental procedures). For such treatment, you agree to pay the charges set by the clinic independent of any dental insurance benefits. You also agree to be treated by dental residents or students under the direct supervision of our licensed dentists and hygienists according to Arkansas state law. Your signed consent acknowledges that all diagnostic aids, including radiographs and/or photographs are the property of the UAMS Oral Health Clinic. By signing, you will retain the right to refuse any or all treatment but this may result in referral for treatment elsewhere. Your signed consent states that it is your responsibility to make and keep all scheduled appointments for yourself and your children or trustees and to complete all planned treatment in a timely manner. You will also sign to give consent for the initial care and all subsequent care for your children or trustees unless affirmatively revoked in writing. The General Consent for Treatment form also has a section for signature which indicates that you consent to accept "assignment of dental benefits" if insured.

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES

NOTICE OF PRIVACY PRACTICES

Effective Date: April 8, 2013

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 is provided on behalf of the University of Arkansas for Medical Sciences including its Medical Center and clinics, Psychiatric Research Institute, Area Health Education Centers, and other facilities ("UAMS"). UAMS provides patient care through a healthcare system committed to education and research.

PURPOSE: This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. "Protected Health Information" is information that may identify you and that relates to your past, present or future physical or mental health, and may include your name, address, phone numbers and other identifying information.

We are required to give you this Notice and to maintain the privacy of your Protected Health Information. We must abide by this Notice, but we reserve the right to change the privacy practices described in it. A current version of this Notice, with required revisions, if any, may be obtained from the UAMS web site, http://www.uamshealth.com/ and will be posted in prominent areas of our facilities. You may also receive a current copy by sending a written request to the UAMS HIPAA Office, 4301 W. Markham #829, Little Rock, AR 72205.

We understand that medical information about you and your health is personal and confidential, and we are committed to protecting the confidentiality of your medical information. We create a record of the care and services you receive at UAMS. We need this record to provide services to you and to comply with certain legal requirements. This Notice will tell you about the ways we may use and disclose your information. We also describe your rights and certain obligations we have to use and disclose your health information.

If you believe your privacy rights have been violated, you may complain to us or to the U.S. Secretary of Health and Human Services. To file a complaint with us, you may send a letter describing the violation to the UAMS Privacy Officer, 4301 W. Markham #829, Little Rock, AR 72205. There will be no retaliation against you for filing a complaint.

If you have questions or need more information, contact the UAMS HIPAA Office at 501-614-2187.

WHO WILL FOLLOW THIS NOTICE: This Notice describes the practices of UAMS healthcare professionals, employees, volunteers and others who work or provide healthcare services at any UAMS facility, including students-in-training.

ACKNOWLEDGMENT: You will be asked to sign an Acknowledgment of receipt of this Notice. The delivery of your healthcare services will in no way be conditioned upon the signing of this Acknowledgment.

Your Privacy Rights. You have the following rights relating to your Protected Health Information. You may:

- Obtain a current paper copy of this Notice.
- Inspect or obtain a copy of your records, in paper or electronic form. You may be charged a fee for the cost of copying, mailing or other supplies. We are allowed to deny this request under certain circumstances. In some situations, you have the right to have the denial of your request reviewed by a licensed healthcare professional identified by UAMS who was not involved in the original denial decision. We will comply with the outcome of this review.
- Request that we amend your record, if you feel the information is incomplete or incorrect. We are allowed to deny this request in certain circumstances and may ask you to put these requests in writing and provide a reason that supports your request.
- Request in writing a restriction on certain uses and disclosures of your information. We are not required to agree to the requested restrictions, unless you are requesting to restrict certain information from your health plan and you have paid for your UAMS services in full.
- Obtain a record of certain disclosures of your Protected Health Information.
- Make a reasonable request to have confidential communications of your Protected Health Information sent to you by alternative means or at alternative locations.
- Provide us with written permission for uses and disclosures of your Protected Health Information that are not covered by the Notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may cancel this permission. This request to cancel must be put in writing.
- Submit any written requests to inspect, copy or amend your records to the UAMS Health Information Management Department.

Our Responsibilities. We are required to protect the privacy of your Protected Health Information, abide by the terms of the Notice, and make the Notice available to you. We are also required to notify you if a breach of your health information occurs.

Examples of Uses & Disclosures

We will use your Protected Health Information for treatment. Certain information obtained by a nurse, doctor, therapist, or other healthcare worker will be put into your record and used to plan and manage your treatment. We may provide reports or other information to your doctor or other authorized persons who are involved in your care, including healthcare providers outside of UAMS We may make your protected health information available electronically through an electronic health information exchange to other health care providers and health plans that request your information for their treatment and payment purposes. Participating in an electronic health information exchange may also let us see their information about you for our treatment and payment purposes.

We will use your Protected Health Information for payment. A bill will be sent to you and/or your insurance company with information about your diagnosis, procedures and supplies used. We may also disclose limited information about your bill to others, such as a collection agency, to obtain payment.

We will use your Protected Health Information for regular healthcare operations. UAMS may use your Protected Health Information to check on the care you received, how you responded to it, and for other business purposes related to operating the hospital or clinics. UAMS is a teaching facility, and information about you may be shared with students and trainees for teaching purposes.

Business Associates: We may share some of your Protected Health Information with outside people or companies who provide services for us, such as typing physician reports.

Patient Directory: Unless you tell us not to, we may disclose your name, location in the facility, and general condition to people who ask for you by name. If provided by you, your religious affiliation may also be given to members of the clergy.

Notification: We may use or disclose your Protected Health Information to notify a family member or other person involved in your care, your location and general condition unless you tell us not to do so.

Communication with family: We may share your Protected Health Information with a family member, a close personal friend, or a person that you identify, if we determine they are involved in your care or in payment for your care, unless you tell us not to do so.

Research: Your Protected Health Information may be used for research purposes in certain circumstances with your permission, or after we receive approval from a special review board whose members review and approve the research project.

Coroners, Medical Examiners, Funeral Directors: In the event of your death, we may disclose your Protected Health Information to these people, to the extent allowed by law, so that they may carry out their duties.

Organ Donor Organizations: We may share your Protected Health Information with the organ donation agency for the purpose of tissue or organ donation in certain circumstances and as required by law.

Contacts: We may contact you to provide appointment reminders or to tell you about new treatments or services.

Fundraising and Marketing: We may contact you as part of UAMS fundraising or marketing efforts. You have a right to opt out of Fundraising communications and may do so by calling 1-888-995-UAMS (8267) or emailing advancement@uams.edu.

Food and Drug Administration (FDA): We may share your Protected Health Information with certain government agencies like the FDA so they can recall drugs or equipment.

Workers Compensation: We may disclose your Protected Health Information for workers' compensation claims.

Public Health: We may give your Protected Health Information to public health agencies who are charged with preventing or controlling disease, injury or disability and as required by law.

Communicable Disease: We may disclose your Protected Health Information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition, if authorized by law to do so, such as a disease requiring isolation.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose your Protected Health Information to the institution or law enforcement as needed for your health or the health and safety of others.

Law Enforcement: We must disclose your Protected Health Information for law enforcement purposes as required by law.

As Required by Law: We must disclose your Protected Health Information when required by federal, state or local law, such as to report gunshot wounds.

Health Oversight: We must disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as investigations and inspections. Oversight agencies are those that oversee the healthcare system, government benefit programs, such as Medicaid, and other government regulatory programs.

Abuse or Neglect: We must disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect involving children or endangered adults.

Legal Proceedings: We may disclose your Protected Health Information in the course of any judicial or administrative proceeding or in response to a court order, subpoena, discovery request or other lawful process, as allowed by law.

Required Uses and Disclosures: We must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy Regulations.

To Avoid Harm: We may use and disclose information about you when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.

For Specific Government Functions: In certain situations, we may disclose Protected Health Information of military personnel and veterans. We may disclose your Protected Health Information for national security activities required by law.

Sale of Information: UAMS will not sell your information without your prior written authorization or as otherwise allowed by law.

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501-526-7619 (phone)
501-526-4544 (fax)

UAMSOralHealthClinic@uams.edu

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UAMS

DELTA DENTAL OF
ARKANSAS FOUNDATION
ORAL HEALTH CLINIC

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES

HIPAA INFORMATION RELEASE

I authorize the persons named below to discuss my dental treatment with the dentists and staff of the Delta Dental of Arkansas Foundation Oral Health Clinic:

Name:________________________**Relationship:**__________________

Name:________________________**Relationship:**__________________

Name:________________________**Relationship:**__________________

Patient:________________________**Date of Birth:**__________________

Patient Signature:____________________________________

Date:____

This authorization will remain valid unless revoked in writing by the patient or legal guardian.

University of Arkansas for Medical Sciences Oral Health Clinic

General Consent for Treatment and Assignment of Dental Insurance Benefits for:

Legal Name (Print) ____

For the purpose of full disclosure, you have been given copies of the UAMS "Notice of Privacy Practices" form and the UAMS Oral Health Clinic "Clinical Policies and Patient Rights" form. By signing and dating below, you are providing certain consents to proceed which allow us to provide actions on your behalf or in behalf of others you may represent. We are grateful that you have chosen UAMS for your dental needs, and we appreciate your patience and cooperation with the uniform application of UAMS policies.

I. General Consent for Treatment, Receipt of Policy Statements, and Release of Information

A. I hereby apply to the University of Arkansas for Medical Sciences Oral Health Clinic for admission, and give permission to complete various indicated dental treatments (including local, oral, and inhalation anesthetics with surgical dental procedures). I have carefully and accurately completed a written medical history and agree to update my medical information at each clinic visit. It is understood that the UAMS Oral Health Clinic is for instruction of and demonstration to the residents and students. I hereby agree that I may be treated by dental residents or students under the direct supervision of licensed dentists and hygienists according to state law. I understand that all diagnostic aids, including radiographs and/or photographs are the property of the UAMS Oral Health Clinic. I have the right to refuse any or all treatment at which time I may be referred for treatment elsewhere. Upon acceptance of the recommended treatment, it is my responsibility to make and keep all scheduled appointments and to complete the planned treatment in a timely manner.

B. I have received a copy of the UAMS "Notice of Privacy Practices" form and the UAMS Oral Health Clinic "Clinical Policies and Patient Rights" form. My signature below confirms that I agree to abide by all stated policies.

C. I authorize the UAMS Oral Health Clinic to release any and all medical/dental information to my insurance company(s) or other physicians or hospitals involved in my treatment or for treatment of my children or trustees.

Signature ____ Date ______________________________

II. Consent for Children and Minors Under 18

I hereby give my consent for initial care and all subsequent care to the Oral Health Clinic faculty, residents, and students to provide any and all necessary dental services for my child unless affirmatively revoked in writing.

Child/Minor's name____________________________________ Relationship to patient ______________________

Signature ____ Date ______________________________

III. Assignment of Dental Insurance Benefits

When applicable, my signature below indicates that I consent to allow the Oral Health Clinic to accept "assignment of benefits" for my/my beneficiaries dental insurance plan and authorize all plan payments be made directly to the OHC.

Signature ____ Date ______________________________

State relationship if other than patient

PATIENT TO RETAIN COPY OF POLICY

UAMS

DELTA DENTAL OF ARKANSAS FOUNDATION ORAL HEALTH CLINIC

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

SUBJECT:	ORAL HEALTH CLINIC: **Termination of Patient Care**	
AREA:	Clinic Business Procedures	
DATE:	July 14, 2016	

It is acceptable to terminate patient care and provider/patient relationships under certain circumstances. When such an action is needed, Oral Health Clinic staff members may meet with the Clinic Director to discuss specific details when necessary. The Oral Health Clinic Director will contact the Center for Dental Education Department Administrator to begin the termination of care process. The Department Administrator may request written documentation justifying the termination action. The Department Administrator may consult with college and department administration and/or UAMS General Counsel before taking immediate action.

It is the policy of the Delta Dental Foundation of Arkansas Oral Health Clinic to terminate patient care and provider/patient relationships under the following circumstances:

- **Treatment noncompliance** – The patient does not or will not follow up on a prescribed treatment plan that is deemed necessary to obtain/maintain acceptable oral health. A good faith effort must be made by clinic staff to educate the patient to the consequences of treatment non-compliance. Documentation must be present in the patient record that the patient does not comply with reasonable instruction for treatment (at-home or in-office).

- **Failed Appointments/Follow-up noncompliance (includes appointment cancellation policy)** – The patient repeatedly no-shows and cancels follow-up visits. Clinic staff will ensure that patients are afforded appointment reminders through the clinic electronic reminder system and office staff telephone calls. It is the patient's responsibility to keep scheduled appointments. **The Oral Health Clinic requires notification of appointment cancellation at least 24 hours in advance or earlier when possible.** An appointment is considered failed any time a patient has not given 24 hours advance notice of cancellation or has failed to arrive before their appointment time. When a patient needs to cancel an appointment that is scheduled on a Monday, notification of the cancellation must be received by the Friday prior in order to not be considered a failed appointment. **Patients who fail three appointments within a 3-year period, or who fail their first appointment, will no longer be allowed to schedule appointments in the Oral Health Clinic**. Patients who fail an appointment with a student or resident dentist will not be able to reschedule with a student or resident. Patients that fail 8:00am appointments, can no longer schedule appointments prior to 10:00am.

  Late arrivals will be seen at the discretion of the Clinic Manager. If clinic & provider schedules permit, late arrivals may be seen during the remainder of their scheduled appointment time. If the remaining appointment time is not sufficient to render services, the appointment will be considered a failed appointment.

- **Verbal abuse** – The patient or a family member is rude and uses improper language with office personnel, exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions.

- **Nonpayment** —The patient owes an outstanding and has made no effort to arrange for payment. Patient accounts in 90+ day outstanding status may be turned over to a collection agency and will be handled per department procedure.

- **Noncompliance or disregard to institutional & department policies** – The patient disregards or will not comply with institutional or departmental policies. Additionally, a termination of care under this category can apply to patient disregard or noncompliance to state and local law(s). A termination of care can be issued when the patient fails to adhere to policies, regulations, and law that create a liability against the health care provider and/or facility. In necessary circumstances, institutional, local, or state authorities will be contacted and be made aware of behaviors described above.

Notification of termination of care

Upon determination of a patient's termination of care, the Director of the Oral Health Clinic with the assistance of the Department Administrator will notify the patient in writing of decision. Elements of the written notice must include the following: reason for termination (general or specific), effective date, interim care provisions, continued care provisions, extension of patient record copies, and patient responsibility. A patient must be given 30 days advance notice of termination in order to have the opportunity to seek other opportunities for oral health care. In most cases, the health care provider(s) must provide, at a minimum, emergency care for a patient whose care has been terminated during the 30 day window mentioned above. Written & signed (original) notifications will be sent to the patient by both standard USPS mail and by certified USPS mail.

DELTA DENTAL OF
ARKANSAS FOUNDATION
ORAL HEALTH CLINIC

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES

Acknowledgement of Receipt:
Delta Dental Foundation of Arkansas Oral Health Clinic
Termination of Patient Care Policy
(Includes Cancellation Policy)

I have received a copy of the Delta Dental Foundation of Arkansas Oral Health Clinic "Termination of Patient Care" policy. Contained within the policy is information regarding appointment cancellation procedures and a patient's responsibility to keep and adhere to scheduled appointment times.

As stated in the "Termination of Care" policy: The Oral Health Clinic requires notification of appointment cancellation at least 24 hours in advance or earlier when possible.

My signature and marks below confirm that I understand and will abide by all stated policies.

Printed Name: ____

Signature: ____

Date: ___________________________________

______ I am the patient being treated.

______ I am signing the form as parent or guardian of patient being treated. (If marked, please complete information below.)

Patient's Name: ____

Relationship to Patient: ____

DELTA DENTAL FOUNDATION OF ARKANSAS ORAL HEALTH CLINIC
PATIENT FINANCIAL RESPONSIBILITY POLICY

Effective January 2, 2015, the Delta Dental Foundation of Arkansas Oral Health Clinic at UAMS (hereafter referred to as the Oral Health Clinic) will enforce the following financial responsibility policy:

PAYMENT IN FULL AT TIME OF SERVICE

Complete payment for services is due on the date services are rendered (including deductibles and co-payments). If services are to be filed on a dental insurance claim, an estimate of insurance coverage will be provided to the patient and the remaining amount (patient portion) is due on the date of service. Self-insured (self-pay) patients will be required to pay the entire amount for services rendered on the date of service.

If payment cannot be provided on the date of service, the patient will be given the option to reschedule his/her appointment to a later date. Extended payment plans will not be permitted. Accepted forms of payment include cash, check, VISA, MasterCard, Discover, and American Express.

Payment in full is required on the date of service for procedures not covered by dental insurance or other third party coverage (i.e., Medicaid, cafeteria plans, etc.)

An adult (parent, guardian, or other) that accompanies a minor/child to an appointment is responsible for any payment due at the time of service. It is the parent's/legal guardian's responsibility to coordinate with the accompanying adult for payment. Unaccompanied minors will be denied treatment unless previous arrangements have been made.

Dentures, partial dentures, crowns, implants, & veneers (dental work requiring impressions & multiple visits to complete) can be paid as follows: 50% of patient's portion (responsibility) must be paid at initial visit & 50% of patient's portion (responsibility) will be due no later than delivery & completion of service.

Account balances accrued prior to the enactment of this policy must be paid in full before future appointments are scheduled and/or services are rendered.

DENTAL INSURANCE

Dental insurance is a contract between the patient and his/her insurance company. The Oral Health Clinic is not a party of the insurance contract. It is a patient's responsibility to understand his/her policy along with its deductibles and maximum benefits. The Oral Health Clinic staff will make every attempt to accurately calculate the estimated amount payable by the patient's insurance company and the estimated amount for which the patient and/or responsible party will be responsible. **PRICES, FEES, OR BENEFITS QUOTED BY ORAL HEALTH CLINIC STAFF ARE ESTIMATES ONLY. FINAL CHARGES OR BENEFITS PAID BY THE INSURANCE COMPANY WILL BE BASED ON WORK PERFORMED AND CLAIMS FILED AFTER WORK HAS BEEN COMPLETE.**

Upon assignment of benefits by the patient, the Oral Health Clinic will bill a patient's insurance company on his/her behalf. To do this properly, the Oral Health Clinic requires that the patient disclose ALL insurance information including primary and secondary insurance, as well as changes that occur in a period between visits to the Oral Health Clinic. Failure to provide complete, current insurance information may result in the patient and/or responsible party being responsible for the entire bill.

It is the patient's responsibility to know if the Oral Health Clinic and its providers are in-network with their insurance plan. If the patient's insurance company is not contracted with the Oral Health Clinic and its providers, the patient is financially responsible for any portion of charges not covered by the insurance company including, but not limited to, charges above the usual and customary allowance. If an out-of network claim is submitted on behalf of a patient and the insurance company processes payment directly to the patient, the patient will be required to make payment in full on the date of service. If, for any reason, an insurance company does not pay for services properly submitted on a dental claim, the patient and/or responsible party will assume full responsibility of the unpaid account balance. If insurance does not pay benefits within 60 days from proper claim submission, the patient and/or guarantor will become responsible for the unpaid account balance. If insurance settles a claim

after 60 days and payment is issued to the Oral Health Clinic after having received payment from the patient and/or responsible party, a refund will be issued in the amount of the overpayment.

OUTSTANDING BALANCES

In the event that an account balance is accrued after the date of service, an account statement will be issued to a patient on a monthly basis thereafter. If payment is not received in full no later than ninety (90) calendar days from the first statement date, the account will be turned over to all possible collection options including third party collection agencies, UAMS payroll garnishment (for UAMS employees) and state income tax garnishment through the State Debt-Offset Act.

Patient's Printed Name: ______________________________

Acceptance of Policy

I fully understand and agree to the Delta Dental Foundation of Arkansas Oral Health Clinic's Patient Financial Responsibility Policy as outlined above. I understand that I am financially obligated to pay for all services rendered to the patient named above today and during future appointments according to the terms outlined in the policy.

____ ____________________
Financially Responsible Party's Signature Date

____
Financially Responsible Party's Printed

Relationship to Patient (select one below):

____ Self/Patient

____ Parent/Guardian
Please specify relationship to· patient: ______________________________

____ Other Responsible Adult
Please specify relationship to patient: ______________________________