INDIANA UNIVERSITY

SCHOOL OF DENTISTRY
IUPUI

THE SEAL INDIANA DENTAL SEALANT PROGRAM IS COMING TO YOUR CHILD'S SCHOOL

WHAT WILL THE SEALANT PROGRAM DO?

Seal Indiana will examine your child's teeth and perform the following preventive dental services, as needed: as many sealants on permanent teeth as your child needs, a fluoride varnish treatment, a tooth brush cleaning, oral health education and/ or temporary fillings.

A **dental sealant** is a plastic material that is applied to the chewing surface of back teeth where decay occurs most often. Sealants protect these teeth from plaque and acid that causes decay. Receiving sealants is comfortable, and no anesthetic is required.

A **fluoride varnish treatment** provides added protection against decay for all teeth. However, this will not be provided if the child is allergic to resins or pine nuts

A **temporary filling** consist of cleaning the decay in the tooth and placing a temporary restoration.

DOES MY CHILD QUALIFY?

Your child can take part in this program if your child does NOT already see a dentist at least once a year.

To have your child participate, you must complete the form on the inside right page and return it to school within one week.

If you have questions, call (317) 278-0750.

HOW MUCH WILL IT COST?

After your child is treated, you will receive a report from Seal Indiana, stating what services were provided and the amount you, Medicaid, Hoosier Healthwise, or your insurance will be billed.

OPTION 1: MEDICAID & HOOSIER HEALTHWISE
100% of the fees will be paid.
For information about free dental and medical insurance for children, call Indiana Hoosier Healthwise: 1.800.889.9949.

OPTION 2: REQUEST FREE CARE
Only available if you do NOT have insurance and cannot afford to pay.

OPTION 3: PRIVATE INSURANCE
Your insurance will be charged.

OPTION 4: PAY OUT OF POCKET
Fees will be charged based on income (see chart).

Annual Family Income	Students 11 & Younger	Students 12 & Older
Less than $18,000	$70	$100
$18,000 to $22,999	$80	$110
$23,000 to $27,999	$90	$120
$28,000 to $36,000	$100	$130
More than $36,000	$110	$140

These fees cover all services provided and may be less than shown above, but will not be more.

INDIANA UNIVERSITY SCHOOL OF DENTISTRY NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. **PLEASE REVIEW IT CAREFULLY!**

1. **Purpose:** The Indiana University School of Dentistry follows the privacy practices described in this Notice. For purposes of this Notice, the Indiana University School of Dentistry is defined as all professional staff, employees, trainees and volunteers who perform services at a number of treatment sites including the **Indiana University School of Dentistry Predoctoral, Graduate, Dental Hygiene and Research Clinics, Cottage Corner Dental Clinic, Grassy Creek Dental Clinic, Regenstrief Dental Clinics, University Hospital Dental Clinics, Oral Health Research Institute, Walker Plaza, Seal Indiana: IUSD Mobile Sealant Program (hereinafter IUSD)**. IUSD maintains your health information in records that will be maintained in a confidential manner, as required by law. However, IUSD must use and disclose your health information to the extent necessary to provide you with quality health care. To do this, IUSD must share your health information as necessary for treatment, payment and health care operations. This Notice will remain in effect until we replace it. The terms of this Notice may change at any time.
2. **What are Treatment, Payment, and Health Care Operations?** Treatment includes sharing information among health care providers involved in your care. For example, your physician or dentist may share information about your condition with the pharmacist to discuss appropriate medications; or with radiologists and other consultants in order to make a diagnosis. IUSD will also disclose health information to physicians or other healthcare providers who may be treating you. IUSD may use your health information as required by your insurer or guarantor of payment to obtain payment for your treatment and/or hospital stay. We also may use and disclose your health information to improve the quality of care (health care operations), *e.g.*, for review and training purposes.
3. **How Will IUSD Use My Health Information?** IUSD may use or disclose your health information for the following purposes:
   - **Those involved in your care or payment**: family members or close friends involved in your treatment.
   - **Business Associates**: We contract with outside organizations, called business associates, to perform some of our operational tasks on our behalf. Examples would include billing agencies or a copy service we use when making copies of your health record. When these services are performed, we disclose the necessary health information to these companies. To protect your health information, however, we require the business associate to appropriately safeguard your information.
   - **Disaster relief agency**, if you are involved in a disaster relief effort.
   - **Appointment reminders** (such as voicemail messages, e-mails, text, postcards or letters).
   - **Marketing**: To inform you of possible treatment alternatives, benefits or services related to your health. (You will have an opportunity to refuse to receive this information.) IUSD must obtain an authorization from you for certain uses and disclosures of your information for marketing. IUSD will not sell your information for any purpose without your authorization.
   - **As required by law**: we will disclose your health information when we are required to do so by federal, state or local law.
   - **Public health activities**: including disease prevention, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence.
   - **Health oversight activities** such as audits, inspections, investigations, and licensure.
   - **Lawsuits and disputes**: we may disclose information about you in response to a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.
   - **Law enforcement:** for example, in response to a court order or other legal process; to identify or locate an individual being sought by authorities; about the victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred on IUSD premises; and in emergency circumstances relating to reporting information about a crime.
   - **Coroners, medical examiners, and funeral directors**.
   - **Organ and tissue donation**.
   - **To perform research projects**: IUSD performs medical and dental research. IUSD may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure, among other things, the privacy of your protected health information. IUSD may release information about you to researchers who need to know how many patients have a specific health issue in preparation for proposed research. If a provider caring for you believes you may be interested in, or may benefit from, a research study, IUSD or the research review committee will designate someone to contact you. This individual will see if you are interested in the study, provide you with more information and give you the opportunity to participate or to decline further contact.
   - **To prevent a serious threat to health or safety**.
   - **Military command authorities** if you are a member of the armed forces or a member of a foreign military authority.
   - **National security** and intelligence activities including protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.
   - **Inmates**. Health information about inmates of correctional institutions may be released to the institution.
   - **Workers' Compensation**. Your health information regarding benefits for work-related illnesses may be released as appropriate.
   - **Health Exchanges**: IUSD may participate in certain health information exchanges or organizations. In particular, IUSD may participate in the Indiana Health Information Exchange (IHIE), Indiana Network for Patient Care (INPC) and Regenstrief Institute, Inc. which help to make your protected health information available to other health care providers who may need access to it in order to provide care or treatment to you. At any time, you may change your mind about agreeing to release information to these programs/exchanges by giving notice to IUSD in writing of your decision; however, any information that has been released prior to IUSD receiving your written notice cannot be retrieved.
   - **Fundraising**: IUSD may use necessary protected health information to contact you in an effort to raise money for its operations (fundraising). We may disclose protected health information to a foundation related to IUSD so that it may contact you to raise money to support IUSD, unless you tell us not to contact you for this purpose. If you do not want IUSD to contact you for fundraising, then you may request that IUSD not contact you by informing the Privacy Officer at the address or phone number listed below.
4. **Your Authorization is Required for Other Disclosures.** Except as described above in this Notice we will not use or disclose your health information unless you authorize (permit) IUSD in writing to disclose your information. Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time and it will be effective upon our receipt of the written revocation. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.
5. **You Have Rights Regarding Your Health Information.** You have the following rights regarding your health information, provided that you make a written request to invoke the right on the form provided by IUSD:
   - **Right to request restriction.** You may request limitations on your health information we use or disclose for health care treatment, payment, or operations (*e.g.*, you may ask us not to disclose that you have had a particular surgery), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. You may request a restriction on the form provided by IUSD. The request should be filed by using the contact information at the end of this Notice.
   - Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted. You may request confidential handling of information on the form provided by IUSD. The request should be filed using the contact information at the end of this Notice.
   - Right to inspect and copy. You have the right to inspect and copy your health information regarding decisions about your care including mental health notes, however, mental health records may be withheld if the health care provider determines, in their best judgment, that the information requested is detrimental to the physical and mental health of the patient, or likely to cause the patient to harm himself or another person. Upon written request and reasonable notice, you may request access and/or copies by using the contact information at the end of this Notice. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by IUSD. IUSD will comply with the outcome of the review.
   - Right to request amendment. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment on the form provided by IUSD, which requires certain specific information. The request should be filed using the contact information at the end of this Notice. IUSD is not required to accept the amendment.
   - Right to accounting of disclosures. You may request a list of the disclosures of your health information that have been made to persons or entities other than for health care treatment, payment, or operations in the past six (6) years, but not prior to April 14, 2003. After the first request in a 12-month period, there may be a charge. You may request an accounting of disclosures on the form provided by IUSD. The request should be filed using the contact information at the end of this Notice.
   - Right to a copy of this Notice. You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice at our web site http://www.iusd.iupui.edu.
   - Right to restrict disclosure to a third party payer. If you pay in full for the services provided to you at IUSD, you can require that the information regarding the service not be disclosed to a third party payer since no claim is being made against the third party payer.
   - Right to be notified after a breach of unsecured protected health information. Should IUSD experience a breach of your protected health information which was unsecured, you will be provided notice thereof.
6. **Requirements Regarding This Notice.** IUSD is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. IUSD may change this Notice and these changes will be effective for health information we have about you as well as any information we receive in the future. Each time you register at IUSD for health care services you may receive a copy of the Notice in effect at that time.
7. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with IUSD or with the Office for Civil Rights, U.S. Department of Health and Human Services (dhhs.gov). All complaints must be submitted in writing. *You will not be penalized or retaliated against in any way for making a complaint to IUSD or the Department of Health and Human Services.*

   To file a complaint with IUSD, please submit the complaint in writing to: IUSD Privacy Officer, 1121 West Michigan Street, Indianapolis, IN 46202.

   If you have any questions about this Notice; if you wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or if you wish to obtain a form to exercise your individual rights described in paragraph 5, please contact Ms. Pamela Elliott, Clinics Administrator, by Phone: (317) 274-3536; Fax: (317) 278-6958; E-mail: www.ds-ps@iu.edu; or Mail: Indiana University School of Dentistry, 1121 W. Michigan Street, Indianapolis, IN 46202.
8. **Acknowledgement of Receipt of this Notice.** We request that you sign a separate form acknowledging that you have received a copy of this Notice for review. If you do not wish to sign the acknowledgement or you are not capable of signing, a staff member will record this fact for you. This acknowledgement will be filed with your records.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CHART #

I have received a copy of the Indiana University School of Dentistry Notice of Privacy Practices.

My relationship to the patient who is a minor/child is: ☐ Parent ☐ Legal guardian ☐ Other _____

Signature _____ Date _____

GENERAL INFORMATION & CONSENT FOR TREATMENT

Child's Name _____
FIRST MIDDLE INITIAL LAST

Date of Birth _____ Age _____ Sex: M F School name _____
MONTH/DAY/YEAR

SI 03/11

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Prefer not to answer
☐ Asian ☐ White
☐ Black ☐ Other

Is your child allergic to latex, resin or pine nuts? ☐ Yes ☐ No If yes, please specify _____

Does your child have asthma? ☐ Yes ☐ No

Briefly explain any health issues your child has and/or list medications your child is taking: _____

Does your child need medication before having dental treatment? ☐ Yes ☐ No

Parent/Guardian Name _____ Relationship to child _____
FIRST MIDDLE INITIAL LAST

Address _____ Phone # _____
STREET CITY ZIP CODE

I give Indiana University School of Dentistry (IUSD) permission to provide preventive dental services for my child at this first visit and a follow up visit. Preventive dental services may include dental examination, dental sealants on permanent teeth, fluoride varnish treatment and/or temporary fillings. I give IUSD permission to collect payment from Medicaid, Hoosier Healthwise or insurance on my behalf, and to allow the nurse and the dentist of my choice to obtain my child's dental record from this examination. I understand that if my child is not enrolled in Medicaid/Hoosier Healthwise, a fee will be charged based on my Statement of Ability to Pay. By signing below, I am indicating that I have read and understand the services that will be provided, that I understand the terms of the consent agreement, and that I have the legal authority to give this consent on behalf of the child.

Signature _____ Date _____

STATEMENT OF ABILITY TO PAY

OPTION 1
Medicaid& Hoosier Healthwise

Child's 12-digit Medicaid Recipient ID: _____ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Medicaid and Hoosier Healthwise pay 100% of services. If your child is enrolled in Medicaid or Hoosier Healthwise but has other insurance that must be used first, you must also fill out the Insurance Section (Option 3 below).

OPTION 2
Requestfree care

☐ I have no insurance and I cannot afford to pay. I request free preventive care and sealants for my child

OPTION 3
Private Insurance

Name of insured _____ Employer _____

Insured date of birth _____ Relationship to child _____

_____ Insurance company _____

_____ ID# _____ Group # _____

OPTION 4
Payoutofpocket

I will expect to receive a bill for my child's dental treatment, according to my annual income level checked below (If unchecked, the middle category will be used to determine the fee).

☐ More than $36,000 ☐ $23,000 - $27,999 ☐ Less than $18,000
☐ $28,000 - $36,000 ☐ $18,000 - $22,999

RETURN THIS TO SCHOOL

Cut along this line

THANK YOU FOR TAKING THE TIME TO CONSIDER SEAL INDIANA FOR HELPING YOU PROTECT YOUR CHILD'S TEETH

RETURN THIS FORM WITHIN ONE WEEK TO PARTICIPATE

Indiana State Department of Health

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DELTA DENTAL