KEEP FOR YOUR RECORDS

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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. KEEP FOR YOUR RECORDS

OUR LEGAL DUTY
The privacy of your medical information is important to us. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. We will notify you if your unsecured medical information is breached.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician, school nurse, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our business operations such as reviewing the competence or qualifications of healthcare professionals and evaluating practitioner and provider performance.

Your Authorization: Uses or disclosures not otherwise described in this Notice may be made only with your written authorization. In addition, we must obtain your written authorization to sell your medical information or to use or disclose your information for marketing goods or services to you where we are paid to make the communication. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends and Persons Involved in Your Care: We may disclose your health information to a family member, friend or other person involved in your care to the extent necessary to help with your healthcare or with payment for your healthcare. We may also disclose your medical information to disaster relief organizations to help locate individuals during a disaster. We may also use or disclose your medical information to notify, or assist in the notification, of a family member, a personal representative or a person responsible for your care of your location, general condition or death. If you do not want us to disclose your medical information to family members or others in these circumstances, please notify our HIPAA Officer at 888-833-8441.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Safety: We may need to disclose medical information to law enforcement officials, such as in response to a search warrant or a grand jury subpoena, or to assist law enforcement officials in identifying or locating an individual, to report deaths that may have resulted from criminal conduct, and to report criminal conduct on our premises.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose your medical information to military authorities of Armed Forces or foreign military personnel under certain circumstances; to authorized federal officials for lawful intelligence, counterintelligence, or other national security activities, and to protect the president; and to a correctional institution or law enforcement official having lawful custody of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters, emails or text messages).

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure surveys. These activities are necessary for the government to monitor the health care system, the outbreak of disease, government programs, compliance with civil rights laws and to improve patient outcomes.

Lawsuits and Disputes: We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process.

Other Uses and Disclosures. As permitted or required by law, we may use or disclose your medical information for research purposes; to organizations that handle and monitor organ donation and transplantation; for workers' compensation or similar programs to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness; for public health activities such as to prevent or control disease, injury or disability; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to, or is at risk for contracting or spreading a disease; to medical examiners to identify a deceased person or determine cause of death; or to funeral directors to carry out their duties.

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information and fax your request to the number at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of some disclosures we or our business associates have made of your health information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we restrict our use or disclosure of your health information. We are not required to agree to your request except when disclosure would be to your health plan, you (or someone on your behalf other than your health plan) has paid in full for your health care, the disclosure relates to payment or health care operations, and the disclosure is not otherwise required by law. If we agree to the restriction, however, we will abide by that agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations specified in your written request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon request.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.
Contact Officer: HIPAA Officer
Phone: 888-833-8441
Fax: 888-330-4331
email: hipaaofficer@smileprograms.com
Effective Date: August 1, 2016

KEEP FOR YOUR RECORDS

Revised 8/02/17

NYC Department of Education Oral Health Clinic Program School Parental Consent Form

*SMILE NEW YORK OUTREACH, LLC**

37-30 Review Ave., Suite 102, Long Island City, NY 11101 Phone: 855-469-7473 Fax: 888-330-4331

STUDENT INFORMATION

Student's Last Name: _____
Student's First Name: _____
Date of Birth: _____/_____/_____
Month Day Year

School_____ **Grade**_____

Teacher's Name:_____

Student's Social Security Number: _____
(*Optional, but helpful*)

Sex: ❑ Male ❑ Female

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____

Student Address:_____

_____ ____ _____
City *State* *Zip Code*

IMPORTANT HEALTH QUESTION

Does your child have any medical condition that may complicate dental treatment? This may include heart issues, breathing problems, seizures, allergies, bleeding problems, communicable diseases, immune disorders, etc. If Yes, explain. IF NO, LEAVE BLANK_____

PARENT/GUARDIAN INFORMATION

Mother
Last Name: _____ First Name: _____

Father
Last Name: _____ First Name: _____

Legal Guardian, If Applicable
Last Name: _____ First Name: _____
Relationship of legal guardian to student
❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact Information for parent or guardian

Home Tel: _____ Work Tel: _____
Cell: _____
Email: _____

Additional Emergency Contact
Name: _____
Relationship to Student: _____
Home Tel: _____ Work Tel: _____
Cell: _____
Email: _____

DENTAL INSURANCE INFORMATION

Does your child have Medicaid?
❑ No ❑ Yes: Medicaid ID # _____

Does your child have Child Health Plus?
❑ No ❑ Yes: CHP # _____

Which Plan?
❑ Affinity ❑ Fidelis
❑ Healthfirst ❑ Health Plus Amerigroup
❑ HIP ❑ MetroPlus
❑ WellCare ❑ United Healthcare
❑ MVP ❑ Empire BlueCross BlueShield
❑ Other _____

Does your child have coverage through your employer or any other type of dental health insurance?
❑ No ❑ Yes, Health Plan: _____
Member ID or Social Security Number: _____
Health Insurance Phone: _____
Name of Insured Adult: _____
Birth Date of Insured Adult:_____

If your child does not have health insurance, would you like an In-Person Assistor authorized by the NY State of Health Marketplace to contact you to enroll into health insurance?
❑ No ❑ Yes What is the best time to contact you? _____

PARENTAL CONSENT FOR SCHOOL-BASED ORAL HEALTH CLINIC SERVICES

I have read and understand the services listed on the next page (School-Based Oral Health Clinic Services) and my signature provides consent for my child to receive services provided by the Smile New York Outreach, LLC School-Based Oral Health Clinic for as long as my child is enrolled at school. I may withdraw my consent at any time by written notice to Smile New York Outreach, LLC. I have read the IMPORTANT HEALTH QUESTION above and will report any significant changes in my child's health to 855-481-8638. We may send you text messages about the school dental program. Message and/or data fees may be charged by your wireless service provider; to discontinue, reply "STOP" to any message received from us. You also agree to receive pre-recorded and/or auto-dialed telephone calls relating to the school dental program at the land-line and/or mobile telephone numbers provided on this consent form. NOTE: By law, parental consent is not required for students who are 18 years or older or for students who are parents or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release oral health information as specified.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

NY-NYC-ENG-010V1

Revised 8/02/17

NYC Department of Education Oral Health Clinic Program
School Parental Consent Form

*SMILE NEW YORK OUTREACH, LLC**

37-30 Review Ave., Suite 102, Long Island City, NY 11101
Phone: 855-469-7473 Fax: 888-330-4331

SCHOOL-BASED ORAL HEALTH CLINIC SERVICES

I consent for my child to receive oral health care services provided by the State-licensed health professionals of Smile New York Outreach, LLC as part of the school oral health program approved by the New York State Department of Health for as long as my child is enrolled at school. I may withdraw my consent at any time by written notice to Smile New York Outreach, LLC. I understand that confidentiality between the student and the oral health clinic provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and oral care decisions. School-Based Oral Health Clinic Services may include, but are not limited to, preventative oral health services, restorative services, and emergency procedures. Preventative oral health services include, but are not limited to, comprehensive dental exams, dental hygiene treatments, x-rays, sealants and fluoride treatments. This may also include the application of Silver Diamine Fluoride on back teeth to halt the progression of cavities (The use of Silver Diamine Fluoride may discolor any cavities to a brown or black color). For services other than comprehensive dental exams and preventative oral health services, Smile New York Outreach, LLC shall notify the parent/guardian of the services and treatments to be provided, including but not limited to fillings, extractions, and the use of anesthetics or other medications. If the parent/guardian does not consent, these services shall not be performed.

NEW YORK CITY DEPARTMENT OF EDUCATION'S FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF ORAL HEALTH INFORMATION HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF ORAL HEALTH INFORMATION

My signature on the reverse side of this form authorizes release of oral health information. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing oral health information to be given to the Board of Education of the City of New York (a/k/a New York City Department of Education) as well as school nurses and leaders, either because it is required by law or by Chancellor's regulation, or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this oral health information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, like proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's oral health information, and that I can change my mind at any time and revoke my authorization by writing to the School-Based Oral Health Clinic. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize Smile New York Outreach, LLC School-Based Oral Health Clinic to release specific oral health information of the student named on the reverse page to the Board of Education of the City of New York (a/k/a New York City Department of Education).

I consent to the release from the School-Based Oral Health Clinic to the NYC Department of Education and from the NYC Department of Education to the School-Based Oral Health Clinic, of oral health information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law and Chancellor's Regulations on confidentiality:

Information to Protect Health and Safety:
- Conditions which may require emergency
- Conditions which limit a student's daily activity (Form 103S)
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law).
- Health insurance coverage

My signature on page 1 of this form also gives my consent to Smile New York Outreach, LLC to contact other providers that have examined my child and to obtain insurance information.

Time Period During Which Release of Information is Authorized:
From: Date that form is signed on opposite page
To: Date that student is no longer enrolled in the School-Based Oral Health Clinic

*OHCP = Oral Health Clinic Provider

Patient's Bill of Rights

As a patient of Smile New York Outreach, you have the right to:

1. Understand and use these rights. If for any reason you do not understand or you need help, the Center must provide assistance, including an interpreter.
2. Receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or source of payment.
3. Be treated with consideration, respect and dignity including privacy in treatment.
4. Be informed of the services available at the Center.
5. Be informed of the provisions of off-hour dental emergency coverage.
6. Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care.
7. Receive an itemized copy of his/her account statement, upon request.
8. Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.
9. Receive from his/her dentist information necessary to give informed consent prior to the start of any non-emergent procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the risks involved, and alternatives for care or treatment, if any.
10. Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action.
11. Refuse to participate in experimental research.
12. Express complaints about the care and services provided and to have the Center investigate such complaints, without fear of reprisal. A patient may express their concern verbally or in writing to the administrator. The Center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The Center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the Center's response, the patient may complain to the New York State Department of Health's Office of Health Systems Management by calling 1-800-804-5447.
13. Privacy and confidentiality of all information and records pertaining to the patient's treatment.
14. Approve or refuse the release or disclosure of the contents of his/her dental record to any healthcare practitioner and/or healthcare facility except as required by law or third-party payment contract.