

APPENDIX CP 2



Phoenix College Dental Clinic

Important Information for Our Patients

Thank you for choosing an educational facility for your dental needs. Our Dental Assisting and Dental Hygiene Programs are accredited by the Commission on Dental Accreditation of the American Dental Association and we take pride in offering dental care that meets the highest standards of the professions. We would like to take this opportunity to explain the policies and procedures of our clinical teaching facility.

Dental Hygiene Clinic

Dental hygiene students perform cleanings, take radiographs (x-rays), administer dental anesthesia, give fluoride treatments and apply sealants. They also perform oral cancer exams, check your blood pressure, and pulse and give homecare tooth brushing instructions. The Dental Hygiene Clinic is a teaching clinic: therefore, patients receiving dental hygiene care will be participating in the teaching program. Only patients whose care is suitable for teaching purposes are eligible for treatment in the clinic. New Patients require an initial evaluation or assessment appointment to determine if they are eligible. Patients not offered dental hygiene treatment will be referred for treatment to a dentist of their choice. Some patients may initially qualify for treatment and later, after initial therapy is completed, may no longer be considered appropriate as teaching cases; in this case, services will be discontinued, and a referral will be provided. The dental hygiene faculty reserves the right to refuse or discontinue treatment. Dental hygiene treatment will be performed by a student and will be supervised faculty. Treatment received in our clinic requires **significantly** more time than care provided in a private dental practice.

- Most appointments are approximately three hours in length. For adults, multiple appointments are usually required.
- For children under 18 years of age, a parent or legal guardian must remain in the clinical facility during the appointment and must sign the Consent for Treatment form.
- Individuals who have difficulty reading or speaking English must provide an interpreter at every appointment.
- Scheduling maintenance visits will be the patient's responsibility.
- Patients are responsible for all personal items brought into the Phoenix College dental clinic. Phoenix College will not be responsible for any lost or misplaced personal items.

Patient's Right and Responsibilities

1. Patients of our facility will be given considerate, respectful and confidential treatment. Mutual respect from patients towards the dental clinic team members (faculty, students, dentists, and staff) is expected. **Our goal is to complete any treatment started; however, as an educational facility, we must work within certain constraints and limitation. The educational setting makes it impossible for us to consistently provide patients with long-term care.** We will be happy to give you referral information for dental procedures we cannot provide. Upon your request and consent, we will send your radiographs to the dentist of your choice for a nominal duplicating fee.
2. Our facility is closed approximately FIVE months per year (winter, spring and summer breaks, and all other observed holidays). Due to this limited schedule, we suggest and encourage you to maintain relationships with dental practitioners in the community to ensure that all your dental needs can be met.
3. You will have access to complete and current information about your condition and will be required to give your consent for treatment. You will be provided with an explanation for recommended treatment, alternatives, the option to refuse treatment, and the expected outcome of various treatments.
4. Payment is required prior to services being rendered. We will give you a receipt to send to your insurance company for reimbursed of fees. Fees are honored until the care plan is complete and/or for the duration of the academic year.



APPENDIX CP 2



PHOENIX COLLEGE

A MARICOPA COMMUNITY COLLEGE

Phoenix College Dental Clinic **Important Information for Our Patients**

Termination of Clinician-Patient Relationship Policy

It is the policy of Phoenix College Dental Clinic to maintain a cooperative and trusting clinician-patient relationship with its patients. When such a clinician-patient relationship has not been formed or a clinician-patient relationship is no longer proceeding in a mutually productive manner, it is the policy of the dental clinic to terminate the clinician-patient relationship so that the patient can develop the type of trusting relationship with another dental clinic that is essential to successful continued care and treatment. The dental clinic is associated with an educational program, and, as such, students, faculty/staff, and patients must comply with this policy.

Sexual Harassment and Discrimination Policy

The policy of the Maricopa County Community College District (MCCCD) is to provide an educational, employment, and business environment free of sexual violence, unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct or communications constituting Sexual Harassment as prohibited by state and federal law. Discrimination under this Policy is an unequal treatment of a student based on the student's actual or perceived gender, sexual orientation, or pregnancy. This Policy prohibits Sexual Harassment and Discrimination in any college education program or activity, which means all academic, educational, extracurricular, athletic and other programs.

Sexual harassment is defined as any unwelcome verbal or physical conduct of a sexual nature that is sufficiently severe, persistent, or pervasive that it unreasonably interferes with, limits, or deprives a student of the ability to participate in or benefit from any MCCCD educational program or activity.

Refund Policy

If you choose to discontinue treatment and request a refund from Phoenix College Dental Clinic, you can be refunded. All Refunds will be processed back to the original form of payment through Phoenix College Cashiers Office in Hannelly Center on Phoenix College Campus. Please bring a current photo ID to

Cashiers Office at 1202 W, Thomas Rd., Phoenix, AZ 85013

How to Request a Refund

- Contact Phoenix College Dental Clinic at 602-285-7323 and request a refund OR
- Email refund request to: PC-Dental-Images@phoenixcollege.edu
- Upon receipt of a request for a refund, Phoenix College Dental Clinic will confirm all payments by check have cleared the bank (may take up to 15 business days)

Refund of payment originated through a credit card company must be refunded to the originating credit card account (it may take up to 7 business days for the credit card company to post the payment to the cardholder's account)

Cancellation Policy

You and your appointment time are very important parts of our students' educational training. The students are required to give their scheduled patients who are late a 15-minute grace period. After this grace period, they/we may reassign the appointed time to another patient. If you fail twice to keep a scheduled appointment, we will not be able to reschedule you in our facility. Please call us 24 hours in advance if you are unable to keep ANY scheduled appointment in our facility, and we will be happy to reschedule a more convenient time for you. Our students rely on you for their clinical experience and we all appreciate the time you share with us.

Patient's Name _____ Age _____ Phone _____

Clinic Information and Consent

The purpose of today's appointment is to determine whether or not your dental hygiene treatment needs can be managed in our clinic and to assist us in scheduling your appointments. Please be advised that:

1. This dental hygiene clinic performs dental hygiene procedures primarily to provide student learning opportunities. Our services include dental prophylaxis (cleanings), digital images (x-rays), fluoride treatments, sealants, dental anesthesia and oral health education. All procedures are performed by students under the direct supervision of faculty who are licensed dental professionals.
2. Some patients will be informed at the screening appointment that Phoenix College Dental Hygiene Program will be unable to meet their needs.
3. Appointments are longer than you would experience in a private dental office. If you are unable to commit to several 3 hour appointments, then you may not be eligible for treatment in this facility.
4. Patients will be referred to their own dentist for ongoing dental evaluation. If you do not have a dentist of record, referral information will be made available. We are not a full service dental clinic and are unable to consistently provide patients with long-term dental care.

My signature below indicates that:

1. I have read and understand the above information.
2. I consent to this screening procedure which includes a limited examination of my teeth and gums.
3. I understand that if I am eligible for treatment, and I agree to proceed, then the fee for services must be paid prior to receiving those services.
4. I give my permission to allow my patient records to be used for educational purposes in this setting.

Signature _____ Date _____



Student fills out SCREENING 'Assessment' 'REPORT'

Yes No A medical consultation is necessary prior to proceeding with the screening.

Yes No A medical consultation is necessary prior to appointing the patient for dental hygiene care.

Periodontal Screening

3	9	12
28	25	19

Calculus Screening

3	9	12
28	25	19

Bleeding: None Delayed Slt Mod Heavy Preliminary Calculus Class: L M H H+

Preliminary Assignment: Clinical Heath Gingivitis Patient is ineligible _____
Stage: I II III IV

Treatment Considerations / Comments _____

Student _____ Faculty _____ Date _____

Radiography Order: NONE FMS-HBW FMS-VBW HBW 2 4 VBW 2 3 4 7 PANO OCC PA(S) / Dr. _____

ASSIGN TO STUDENT: _____ # _____ Placed on call list: Y / N

NAME _____

DATE _____

DENTAL HISTORY

Yes No *Do you have dental examinations and cleanings on a routine basis?

Date of last visit _____

Generally, how have you felt about your previous dental appointments?

Very anxious and afraid Somewhat anxious and afraid Don't care one way or the other Look forward to it

*Check any of the following that you have experienced in the past two years:

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> toothache | <input type="checkbox"/> sensitive teeth | <input type="checkbox"/> stains | <input type="checkbox"/> sore jaw | <input type="checkbox"/> spacing between teeth |
| <input type="checkbox"/> abscess | <input type="checkbox"/> bad breath | <input type="checkbox"/> yellowing/graying teeth | <input type="checkbox"/> difficulty chewing | <input type="checkbox"/> clench, grind, brux |
| <input type="checkbox"/> swelling inside mouth | <input type="checkbox"/> sore gums | <input type="checkbox"/> loose teeth | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> swollen face | <input type="checkbox"/> bleeding gums | <input type="checkbox"/> dry mouth | <input type="checkbox"/> food catching between teeth | |
| <input type="checkbox"/> filling fell out | <input type="checkbox"/> tartar buildup | <input type="checkbox"/> burning sensation | <input type="checkbox"/> crowded/crooked teeth | |

Comments _____

HEMOCARE PRACTICES

Check any of the following you regularly use at home:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> soft toothbrush | <input type="checkbox"/> special brush | <input type="checkbox"/> oral irrigator | <input type="checkbox"/> rubber tip |
| <input type="checkbox"/> hard toothbrush | <input type="checkbox"/> dental floss | <input type="checkbox"/> powered interdental cleaner | <input type="checkbox"/> denture cleanser |
| <input type="checkbox"/> medium toothbrush | <input type="checkbox"/> floss threader | <input type="checkbox"/> fluoride rinse, gel or tablet | <input type="checkbox"/> denture adhesive |
| <input type="checkbox"/> powered brush | <input type="checkbox"/> toothpick | <input type="checkbox"/> mouth rinse | <input type="checkbox"/> other _____ |

Check the type of toothpaste you use:

- | | | | |
|---|---|--------------------------------------|---|
| <input type="checkbox"/> fluoride | <input type="checkbox"/> tartar control | <input type="checkbox"/> gum benefit | <input type="checkbox"/> whitening |
| <input type="checkbox"/> sensitivity protection | <input type="checkbox"/> baking soda | <input type="checkbox"/> peroxide | <input type="checkbox"/> multiple benefit |

Estimate how long it takes you to clean your teeth and gums each time:

Brushing _____ Flossing _____

About how many times each day/week do you brush and floss?

I brush about _____ times per day OR _____ times per week

I floss about _____ times per day OR _____ times per week

Yes No Do you have difficulty in adequately cleaning your teeth? (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Difficult to hold toothbrush | <input type="checkbox"/> Difficult to use dental floss | <input type="checkbox"/> Can't brush/floss for any length of time |
| <input type="checkbox"/> Don't see well | <input type="checkbox"/> Other/comments _____ | |

Yes No Don't know Do you live in a fluoridated community?

Yes No Do you use a water filter or bottled water for your main drinking water source?

If yes, type of filter _____ brand of water _____

BEHAVIORS/HABITS

Yes No *Do you use smoking tobacco, chewing tobacco, marijuana, vaping, juuling, and/or hookah? If yes, what form and frequency?

Type (cigarettes, spit tobacco, smoke marijuana) _____ Frequency/quantity _____ How long? _____

Yes No Do you consume alcohol? If yes, frequency/quantity _____

Check the sweets/starches you eat regularly. In the space next to each food, indicate how often you eat these each day:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> breath mints _____ | <input type="checkbox"/> soda/pop _____ | <input type="checkbox"/> chips _____ | <input type="checkbox"/> candy _____ |
| <input type="checkbox"/> cough drops _____ | <input type="checkbox"/> coffee or tea with sugar _____ | <input type="checkbox"/> crackers _____ | <input type="checkbox"/> dried fruits _____ |
| <input type="checkbox"/> chewing gum _____ | <input type="checkbox"/> other sugared beverages _____ | <input type="checkbox"/> cookies _____ | <input type="checkbox"/> other sweets _____ |

BELIEFS/ATTITUDES

How important is it for you to prevent cavities, gum problems or other disease of the mouth?

- | | | |
|---|---|---|
| <input type="checkbox"/> Very important | <input type="checkbox"/> Somewhat important | <input type="checkbox"/> Not at all important |
|---|---|---|

Would you like your dental professional to make specific product recommendations to meet your oral care needs?

- | | | |
|------------------------------|---------------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> I'm not sure | <input type="checkbox"/> No |
|------------------------------|---------------------------------------|-----------------------------|

I believe that I have control over the condition of my mouth. Firmly believe Somewhat believe Do not believe

PATIENT INFORMATION

Today's Date _____

Name _____ Female ___ Male ___
Single ___ Married ___ Minor ___ AGE: _____
Last First Middle I.

Mailing Address _____ Birthdate ___/___/___
Street Apt/Space# City State Zip Code

Contact Information: Telephone: () _____ () _____ () _____ () _____
Home # Work # Cell # Other (Message, Pager)

E-mail address: _____ (optional)

Text Messages: Would you like to receive text messages? ___ YES ___ NO

NOTE: these methods of contact will only be used as contact for appointments and are never sold/shared/distributed in any manner outside the needs of our clinical appointment management needs.

FAMILY INFORMATION - Minor Child? {Fill in **BOTH** blocks} Married? {Fill in **APPROPRIATE** block}

<i>Father (or Husband)- please circle</i>			<i>Mother (or Wife) - please circle</i>		
_____	_____	_____	_____	_____	_____
<i>Last Name</i>	<i>First</i>	<i>Middle</i>	<i>Last Name</i>	<i>First</i>	<i>Middle</i>
Address : _____			Address : _____		
Street	City	Zip Code	Street	City	Zip Code
() _____	() _____	() _____	() _____	() _____	() _____
Home Telephone	Work Telephone	Cell Phone	Home Telephone	Work Telephone	Cell Phone
Birth Date (Month/Day/Year) _____			Birth Date (Month/Day/Year) _____		

EMERGENCY CONTACT - Who shall we contact (friend/family) if you are in need of assistance while in our facility?

NAME _____ RELATIONSHIP TO YOU _____
TELEPHONE # () _____ ADDRESS _____
Street City Zip Code

DENTAL INFORMATION

Reason(s) for this dental appointment? ___ Cleaning ___ Examination ___ Emergency ___ Consultation
Do you have a specific dental problem? ___ Yes ___ No If yes, please explain: _____
Name of previous or current dentist: _____
Date of last dental x-rays: _____ 16 – 20 small films ___ Panoramic film ___

AUTHORIZATION

I understand that Phoenix College Dental Programs and Clinic exist to teach students skills in dental assisting and dental hygiene, that all services offered in the clinic are for this purpose and that several appointments may be necessary for completion of treatment. I give permission for my patient records and photographs to be used in this educational setting.

I also understand that I am responsible for all costs and dental treatments I receive in this facility. Upon being informed of each procedure, I authorize the administration of such medications and performance of diagnostic and therapeutic procedures as may be necessary for appropriate dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

I have read and understand the information contained in the separate patient information sheet provided.

X _____
Signature (If patient is a Minor, Parent or Guardian) Date Signed



Dental Clinic

Important Information for Our Patients

Read and Sign

Dental Hygiene Clinic

Under instructor/dentist supervision, the dental hygiene students may perform the following procedures according to your needs:

- prophylactic cleaning of the teeth - *Most Appointments are **3 hours in length**, and usually takes more than one appointment*

- local anesthesia in conjunction with cleaning
- fluoride treatments

Note:

- radiographs (x-rays) of the dentition
- vital signs (blood pressure) and oral cancer examination
- home-care instruction including brushing and flossing
- photographs of the face and mouth
- only patients whose care is suitable for teaching purposes are eligible for continued treatment in the clinic
- children under the age of 18 must be accompanied by a parent or legal guardian
- individuals who have difficulty reading or speaking English must provide an interpreter at every appointment
- patients are responsible for scheduling recall appointments

Patient's Rights

Patients can expect:

- considerate, respectful, and confidential treatment
- an explanation of recommended treatment and treatment alternatives
- the option to refuse treatment
- access to complete and current information about your condition
- treatment that meets the standard of care in the profession
- referrals for treatment we are unable to provide

Our goal is to provide continuity and completion of treatment. *However, the educational setting makes it impossible for us to consistently provide long-term dental care.*

The Dental Clinic is open approximately 8 months out of the year. *We suggest and encourage you to maintain relationships with dental practitioners in the community to be sure all of your dental needs are met.*

Patient's Responsibilities

Patients are responsible for:

- being on time for your appointment
- being considerate and respectful
- paying for services at the time they are rendered
- signing a consent for treatment
- signing acknowledgment of this information

Termination of Clinician - Patient Relationship Policy

- It is the policy of the dental clinic to terminate the clinician-patient relationship when such a clinician-patient relationship has not been formed or is no longer proceeding in a mutually productive manner.

Sexual Harassment and Discrimination Policy

- The policy of the Maricopa County Community College District (MCCCD) is to provide an educational, employment, and business environment free of sexual violence, unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct or communications constituting Sexual Harassment as prohibited by state and federal law.

Refund Policy

If you choose to discontinue treatment and request a refund from Phoenix College Dental Clinic, you can be partially refunded. All Refunds will be processed back to the original form of payment through Phoenix College Cashiers Office in Hannelly Center on Phoenix College Campus. Please bring a current photo ID to Cashiers Office at 1202 W. Thomas Rd., Phoenix, AZ. 85013.

Cancellation Policy

- You will lose your appointment time if you are more than 15 minutes late
- We will be unable to schedule you in our facility if:
 - you cancel appointments twice with less than twenty-four (24) hours notice
 - you fail twice to keep an appointment

I have read and understand the information contained in this Patient Information Sheet.

X _____

Date _____



HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: _____

Printed Name-Patient or Responsible Party

Patient Signature or Responsible Party Date

Relationship to patient (if other than patient)

Complaints: You may complain to Phoenix College Dental Programs, Chairperson, (602)285-7262, Address: 3144 North 7th Avenue, Website: www.phoenixcollege.edu/dental. If you believe that your privacy rights have been violated, you may also complain to the Secretary of the United States Department of Health and Human Services.

Term of Notice: This notice is effective 9/18/18. The provisions of this notice may change. If they do, a current version of the notice will be published at the website noted above.

HIPAA Privacy Authorization Form

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name:

Relationship:

Contact information: _____

Oral Health Information to be disclosed upon the request of the person named above (Check either A or B):

- A. **Disclose** my complete oral health record (including but not limited dental x-rays, clinical notations, dental hygiene diagnosis, prognosis, treatment, and billing)

OR

- B. **Disclose** my oral health record, as above, **BUT do not disclose** the following (check as appropriate):
- Dental x-rays
 - Medical History information
 - Clinical notations
 - Dental/Periodontal charting information
 - Oral health treatment provided
 - Billing information
 - Other (please specify): _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- An electronic record or access through an online portal
- Hard copy

This authorization shall be effective until (Check one):

- All past, present, and future periods
- OR
- Date or event: _____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your oral health care provider(s), preferably in writing.)

Name of the Individual Giving this Authorization

Date of birth

Signature of the Individual Giving this Authorization

Date



PHOENIX COLLEGE DENTAL CLINIC

1202 W. THOMAS ROAD (mailing address) 3144 North 7th Avenue (physical address)
PHOENIX, AZ 85013
PHONE: 602-285-7323
FAX: 602-441-0453

I (print name of patient) _____, Birth date _____
request the release of my dental records dated _____, including dental films/images, for
diagnostic and hygiene treatment purposes.

X _____ Date: _____

(Patient's/Guardian's Signature)

This signature of request is applicable until revoked by the patient

{Check one below}

___ to the Phoenix College Dental Clinic for the purposes stated above. Digital images may be e-mailed
to: pc-dental-images@phoenixcollege.edu.

___ to / request from: _____ at: (Fax #) _____

(E-mail address): _____

Requested records sent by: _____ on: _____ via: e-mail ___ U.S. Postal ___

Request for records sent by: _____ on: _____ via: e-mail ___ Fax ___ USPS ___

SUBSEQUENT REQUESTS AND FORWARDING

Digital Images dated: _____ Periodontal Charting dated: _____

Notes/Comments: _____

To: (e-mail address): _____

Requested records sent by: _____ on: _____ via: e-mail ___ U.S. Postal ___

Request for records sent by: _____ on: _____ via: e-mail ___ Fax ___ USPS ___

Digital Images dated: _____ Periodontal Charting dated: _____

Notes/Comments: _____

To: (e-mail address): _____

Requested records sent by: _____ on: _____ via: e-mail ___ U.S. Postal ___

Request for records sent by: _____ on: _____ via: e-mail ___ Fax ___ USPS ___

Digital Images dated: _____ Periodontal Charting dated: _____

Notes/Comments: _____

To: (e-mail address): _____

Requested records sent by: _____ on: _____ via: e-mail ___ U.S. Postal ___

Request for records sent by: _____ on: _____ via: e-mail ___ Fax ___ USPS ___