

The Molar Express

« Helping to improve oral health and brighten the smiles of the north country »

Molar Express is a mobile dental clinic that is equipped to provide services typically found in any general dental practice. Our services include: Exams, cleanings, x-rays, fillings, extractions, etc.

We offer:

- School-based clinics: students receive dental care without having to miss a day of school.
- Community-based clinics: Services are offered to both adults and children. Clinics are set up conveniently to serve local communities.

Complete and return these attached forms as soon as possible:

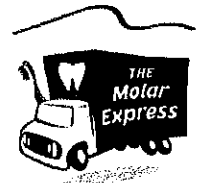
- *The Molar Express - Dental Care Application*
- *Sliding Fee Scale Application*
- *A copy of a "Patient's Rights and Privacy Practices Notice" is on the back of this page - please review and keep this page for your records.*

The Molar Express accepts Healthy Kids Gold, Silver, Private Insurance, Visa, Mastercard, cash and checks. A sliding fee scale, and payment plans are available to those who qualify. (Proof of income may be required for these discounts.)



a North Country Health Consortium program

**Thank-You for your interest in the Molar Express
For More Information ~ Please Call**



a North Country Health Consortium program

The Molar Express, North Country Health Consortium, 7 Main Street, Suite 7, Whitefield, NH 03598
Tel: 603-837-2643x604 ~ Cell: 603-986-5485 ~ Fax: 603-837-9451

Revised May/2010

The Molar Express

Patient's Rights and Privacy Practices Notice

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.

Uses of information and how information is disclosed:

Information given to The Molar Express and its staff may be used for treatment, including: 1) identifying treatment goals agreed upon by both patient and staff; 2) setting a plan of treatment for pursuing those goals; and 3) monitoring effectiveness of the treatment plan. An example of each of these would be: the Dentist suggests a treatment plan for a patient and the patient and Dentist (or the Dentist's representative) talk about the treatment plan and agree on the services to be provided.

Information given to The Molar Express and its staff may be used as The Molar Express and/or its agents seek payment for services, including: 1) mailing invoices to a patient at the address given by patient; 2) submitting patient information to insurance providers, if the patient request this, such as social security number, date of birth, address, dental diagnosis, insurance policy number, and dates of service; 3) writing, phoning, or e-mailing the other payer(s), if the patient requests this, and identifying the patient to seek payment for services; and 4) giving patient information such as social security number, date of birth, address, and dates of services to a collection agency if the patient makes no payment arrangements as per the payment agreement.

Information given to The Molar Express and its staff may be used by The Molar Express and/or its agents for dental care operations, in the sense that the staff will track appointment times and will write in patient chart information about dental diagnosis and treatment services provided. Staff may telephone the patient with appointment reminders and other treatment related information.

Information will be disclosed generally by providing hand delivered materials in sealed envelopes, via United States mail or by talking on the phone, when disclosing is appropriate. However, with a few exceptions (see below), information about a patient will not be disclosed to anyone outside of The Molar Express without patient's written authorization. The patient may revoke such authorization at any time: revoking authorization requires two actions by patient: 1) telling or writing such to staff; and 2) ensuring that their request has been received by staff, for instance asking staff to state understanding that authorization is revoked.

Without the patient's written authorization, information about a patient will not be disclosed to anyone with the following exceptions: 1) if staff determines that the patient or someone else is at risk of eminent physical harm; 2) if staff determines that a child, (meaning anyone under 18 years old) might have been or possibly is being physically harmed, neglected or endangered; 3) if staff determines that a senior (meaning anyone 60 years old or older) might have been or possibly is being physically harmed, neglected, or endangered; 4) if there is a medical emergency; 5) if ordered by a judge. In such situations, staff will provide information deemed useful to ensure safety or to abide by applicable law and may take steps to ensure safety, including for example calling police or arranging a hospital visit.

Patient's Rights:

The Molar Express patients has the right to; 1) request restrictions on certain uses and disclosures of protected health information, although The Molar Express is not required to agree to the request; 2) receive confidential communications of the patient's protected health information; 3) inspect and copy protected health information; 4) request to amend protected health information; 5) receive an accounting of disclosure of protected health information; and 6) receive a copy of this notice upon request.

Responsibilities of The Molar Express:

The Molar Express is required by law to: 1) maintain the privacy of protected health information and to provide patients with notice of this responsibility; and 2) follow the terms of this notice whenever transmitting patient information by computer and 3) offer patients a revised copy of notice if The Molar Express revises this notice in the future.

Complaints:

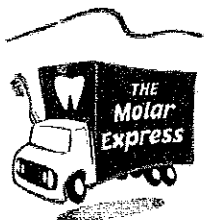
If you believe your privacy rights have not been upheld, you may inform The Molar Express and its staff at 837-2643 ext. 604.

The best approach for addressing such complaints would be to discuss it with The Molar Express staff. If after doing this you are not satisfied, you may call the HIPPA Hotline at 866-627-7748 or www.cms.hhs.gov/hippa.

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The Molar Express Dental Care Application

North Country
Health Consortium, Inc.
Working together to improve the health of North Country residents.

The Molar Express program is for people of all ages who **do not** have a regular dentist **or** have insurance that their dentist does not accept, **or** are not able to get dental care for other reasons. Before any patient is accepted into the program The Molar Express staff will review the application to be sure that this program is appropriate.

#1: PATIENT INFORMATION

Name of Patient _____ SS#: _____ - _____ - _____

Address _____

City _____ State _____ Zip _____

Patient's Date of Birth _____ Age _____ Sex _____

Name of Parent or Guardian: _____

Name of School Child Attends: _____

Home phone: () _____ Work phone: () _____ Cell phone: () _____

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WE COULD CONTACT?

Name: _____ Relation: _____

Home #: _____ Work #: _____

#2: INSURANCE INFORMATION

Person Responsible for payment:

Does the patient have dental insurance? YES ___ NO ___ (If No) _____

Name of Primary Policy Holder: _____ SS# _____ - _____ - _____

Primary policy Holders Address: _____ D/O/B: ___ / ___ / ___

Ins Co. _____ Ins # _____

Please have your insurance card available at time of appointment to ensure eligibility.

#3: PATIENTS CONSENT

I understand that the information that I have provided today is correct to the best of my knowledge. I also understand that this information is strictly confidential and it is my responsibility to inform this office of any changes in my medical health. **I understand that I am responsible to pay all charges if my insurance does not pay.**

By signing I authorize NCHC-MOLAR EXPRESS to perform any of the necessary dental services that I may need during the diagnosis and treatment with my informed consent.

Name of Patient: _____ Date of Birth ___ / ___ / ___ (mm/dd/yyyy)

Patients Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

PRIVACY PRACTICES - HIPPA: I acknowledge that I have read the Molar Express Notice of Privacy Practices. INITIALS: _____ DATE: _____

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#4: Medical History

Doctor's Name _____ Doctor's Phone _____

Your current physical health is: _____ GOOD _____ FAIR _____ POOR

Do You smoke or use any other form of tobacco? YES _____ NO _____

Do you have any of the following medical conditions? Please circle YES or NO to each.

- | | |
|---|--|
| YES NO Heart murmur | YES NO Emphysema |
| YES NO Heart Attack / Stroke | YES NO Epilepsy / Seizures / Fainting Spells |
| YES NO Anemia | YES NO Fever Blisters / Herpes |
| YES NO Abnormal Bleeding / Hemophilia | YES NO Back Problems |
| YES NO Arthritis | YES NO Hepatitis (If yes, TYPE: _____) |
| YES NO Artificial Bones / Joints / Valves | YES NO High / Low Blood Pressure |
| YES NO Blood Transfusion | YES NO HIV+/AIDS |
| YES NO Cancer / Chemotherapy | YES NO Kidney Problems |
| YES NO Diabetes | YES NO Mitral Valve Prolapse |
| YES NO Drug / Alcohol Abuse | YES NO Psychiatric Problems |
| YES NO Rheumatic / Scarlet Fever | YES NO Tuberculosis (TB) |
| YES NO Severe / Frequent Headaches | YES NO Ulcers / Colitis |
| YES NO Venereal Disease | YES NO Asthma |
| YES NO Sinus Problems | YES NO Hyperactivity (A.D.D. / A.D.H.D.) |

***If you marked "YES" to any items on the above list, please explain: _____

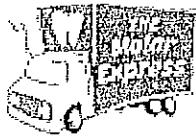
Please List any other medical conditions you have or have had that are not listed above: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? Please Circle YES or NO to each.

- | | | |
|-----------------------|-----------------------------------|---------------------------|
| YES NO Latex | YES NO Penicillin | YES NO Dental Anesthetics |
| YES NO Metals/Jewelry | YES NO Foods (Please list): _____ | |

***Please list any other allergies not listed above: _____

Please list any medications that you are currently taking: _____



Sliding Fee Scale Application



SLIDING FEE SCALE PROGRAM

North Country Health Consortium has a Sliding Fee Scale program that you may be eligible for. This discount is based on your income and family size. If you wish to apply, please complete this section. Please note that your application can only be processed after proof of income documents for all adults in the household, are received. Examples of proof of income documents include: current pay stubs, most recent income tax forms or explanations of benefits.

Applicant's Name _____

Name of Employer /Income Source _____

Weekly Paycheck Before Taxes/Deductions _____

Other Income (child support, alimony, etc) _____

Total Income _____

Insurance: Plan Name _____

Group #: _____

Social Security #: _____

Date of Birth: _____

Number of People in Your Household

How many are adults over 18? _____

How many are children? _____

Is anyone in your household pregnant? _____

CERTIFICATION

I certify that the financial information given is true to the best of my knowledge. I understand that if I give false information, I am liable for fraud. We reserve the right to further check your income.

Address _____

Telephone: _____

Home # _____

Cell # _____

Patient Signature _____

Work # _____

Staff Use Only

Eligibility (circle one) 25% 35% 55%

Date _____

NCHC Staff Signature