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Baltimore City Community College
Dental Hygiene Clinic
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.

Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

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. This notice takes effect 4/14/2003 and remains in effect until we replace it.

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, healthcare operations and educational purposes. For example:

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

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals evaluating practitioner and provider performance, conducting training programs, accreditation, certification and licensing or credentialing activities.

Educational Purposes: All or portions of records may be used for teaching, research, publications and other educational purposes by students and faculty of the college.

Your Authorization: In addition to our use of your health information for treatment, healthcare operations and educational purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. 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: We must disclose your health information to you as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, we will provide you with an opportunity to object to such uses or disclosures prior to use or disclosure of your health information. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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, 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.

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Baltimore City Community College
Dental Hygiene Clinic

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of Baltimore City Community College Dental Hygiene Clinic's notice of privacy practices.

Signature of patient or guardian: _____

Date: _____

For office use only

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices; however, acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify)

_____

_____

_____

_____

_____

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BALTIMORE CITY COMMUNITY COLLEGE
PREVENTIVE DENTISTRY CLINIC
INFORMATION AND CONSENT

Please read the following information carefully so that you will understand the conditions under which clients are treated in the clinic. At the bottom of the page, we would like you to sign your name indicating that you understand these conditions and that you give permission for necessary treatment and for the faculty's use of your treatment records (radiographs, study casts, photographs, etc…) for educational purposes. You should understand that:

1. Treatment in the clinic proceeds more slowly than that in a private office since the services are rendered by the students and are carefully evaluated by faculty members. Completion of procedures cannot be guaranteed in any specific period of time. Generally, preventive treatment appointments are two to three hours in length and patients may visit the clinic more than one time.

2. The dental hygiene students have a certain amount of time set aside to complete their requirements. Their time, like yours, is very valuable. Failure to keep appointments without a 24-hour advance notice, too many cancellations, or being late to appointments for whatever reason may lead to your dismissal as a clinic patient.

3. All records are the property of the department. Radiography films may be sent to your private dentist upon request with approval of the clinical dentist. All or portions of records may be used for teaching, research, publications and other educational purposes by students and faculty of the college.

4. The college and department reserve the right to refuse to provide treatment if the patient does not or will not accept recommended treatment and procedures, including radiographs. Radiographs (xrays) will be taken based on patient need.

5. Services provided are considered to be preventive and not diagnostic in nature; therefore, patients should seek additional care from a private dentist or clinic. The faculty or students cannot be held responsible for a non-diagnosis.

Having read the above, I verify that I understand the information contained herein, and I grant authority to Baltimore City Community College, Department of Dental Hygiene to perform those procedures deemed necessary. I give permission for release of my records to and from my dentist and/or physician. I also agree to make payment for services in accordance with my treatment plan. I confirm that the information on my medical/dental questionnaire is correct to the best of my knowledge.

_____ _____

Witness Patient's Name Printed

_____ _____

Date Patient's Signature

_____

Signature of Patient's Agent and
Relationship or Authorization to sign

BALTIMORE CITY COMMUNITY COLLEGE
PREVENTIVE DENTISTRY CLINIC
PATIENT BILL OF RIGHTS

As a patient in our clinic, it is important to the faculty, students and staff to meet your needs and expectations. We are hopeful that the following rights, when observed, will contribute to safe, efficient, and effective patient care. In addition, we trust that you will appreciate the care provided to you.

Dental Hygiene Clinic patients have the right to:

• Confidentiality of all information pertinent to their care.
• Informed consent prior to the initiation of treatment.
• Be treated with courtesy and respect.
• Participate in decisions regarding their dental hygiene treatment after receiving an explanation of recommended treatment, treatment alternatives, risks and expected outcomes.
• Have a thorough examination and assessment of their oral health needs.
• Receive complete, accurate and current information regarding their oral health status.
• Be informed of dental treatment necessary to attain optimal oral health and wellness.
• Expect high quality care which meets the standard of care in the profession, and which will prevent further disease.
• Expect reasonable continuity of care and completion of treatment.
• Expect treatment in a safe, clean health care setting.
• Expect faculty, staff, and students to be educated on and immunized against Blood-Bourne Pathogens. As a part of the curriculum, students will be educated on CDC Guidelines and OSHA Standard Precautions and Universal Precautions in DH 150 Pre-Clinical Dental Hygiene course prior to treating patients. The faculty and staff will be trained on CDC Guidelines and OSHA Standard Precautions and Universal Precautions as part of the licensure cycle and/or annually.
• Receive treatment that meets the standard of care in the professions without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, medical condition, HIV/AIDS status.
• Receive oral health instructions.
• Be referred for other needed treatment which will promote wellness.
• Have appointment time reasonably observed.
• Be informed of the fee schedule and appointments.

_____ _____

Date Patient's Signature

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BALTIMORE CITY COMMUNITY COLLEGE
PREVENTIVE DENTISTRY CLINIC
REQUEST FOR RADIOGRAPHS

I understand that Baltimore City Community College Dental Hygiene Clinic is closed on the following dates: The first week of May through September 4th and the first week of December through February 1st. All dentists' request for patient radiographs must be received two weeks prior to the end of each semester.

Due to the fact that this is a teaching facility and there is no staff during these times, I understand that I will not be able to receive a copy of my x-rays/radiographs during these times or any times when the students are not in class. (i. e. holidays, spring break)

I further understand that the only information which can be transferred from my record are the progress notes of my treatment. All paperwork done by the students is a training/teaching exercise and thus cannot be transferred out of the clinic.

I have read the above statements and understand:

_____ _____
Signature Date

_____ _____
Witness Date

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Patient ID: _____
Case ID: _____

BALTIMORE CITY COMMUNITY COLLEGE
PREVENTIVE DENTISTRY CLINIC
PATIENT INFORMATION FORM

PLEASE PRINT ALL INFORMATION CLEARLY

Student ID: _____

Today's Date: _____

Patient Name: _____
Last First Middle

Street Address**:** _____

City: _____ State: _____ ZIP Code: _____

Home Telephone: _____ Business/Cellular Telephone: _____

Email Address: _____

DOB: _____ Age: _____ Sex: Male Female

Occupation: _____

Race: Black White Hispanic Asian/Pacific Islander Native American Other

Date of last visit to dentist: _____/_____
MO YR

Referred to clinic by: _____

DO NOT WRITE BELOW THIS LINE

Oral Hygiene Care:	Good	Fair	Poor
Deposit Classification:	One	Two	Three
Pockets:	Yes	No	

Periodontal Classification: _____/_____ /_____

Examination Date: _____/_____ /_____ Recall Appointment _____/_____

Instructor's Signature: _____