UNIVERSITY OF LOUISVILLE
SCHOOL OF DENTISTRY

(502)852-5096

Screening & Appointments

Emergency Care

Patient Services

Mon-Fri 8:30AM-4:30PM

Our Mission

The University of Louisville School of Dentistry, through excellence in teaching and research, will educate competent dental professionals. The School will provide quality dental care and will serve the community to fulfill our urban and statewide missions.

About the School

The University of Louisville has been providing dental care for over 100 years. It offers a full range of general and specialty dental services to the public. The School takes pride in the quality of care and personal service it provides to its patients. You will be cared for by professional and friendly personnel who will help you achieve excellent oral health. Dedicated dental students, dental hygiene students and dental residents provide the majority of treatment, which is supervised and evaluated by our faculty. Your dental care will take a longer period of time; however, you are assured of personal attention and supervision.

To Our Patients...

Patient Care Information

Educating dental practitioners is an important mission of the School. Therefore, patients are accepted for treatment in the student clinics if their treatment needs are appropriate to satisfy educational objectives. Each patient is assigned to a dental student for general dental care. Once a patient is assigned to a comprehensive care group, they are contacted for additional appointments. Upon completion of treatment, patients are appointed for regular cleanings and examinations to keep their teeth and gums healthy.

Your Responsibilities

As a patient, please understand that the School of Dentistry is an educational institution where all students, faculty, staff and patients are accepted regardless of age, race, nationality, gender, reprisal, religious, disability, family, social status, or sexual orientation. It is our responsibility, as well as yours, to treat everyone in the clinic with courtesy and respect.

Please remember: Being a patient of the dental school may require more visits than private practice. Patients need to be available for a three-hour appointment at least twice a month.

*If your dental needs are too complex for the student clinics, you may be referred to an advanced education program, or to private practice to better suit your dental needs.

Emergency Care

All patients are eligible for urgent care at the School of Dentistry.

Emergencies are by appointment or walk-in.

The ULSD Emergency clinic can be reached at 502-852-5096. Assigned patients may also call their dental student.

For emergency care after 5:00 PM on weekdays, and on weekends and holidays, our patients should call 502-852-5096 for information on how to receive care.

Fees and Insurance

There will be a charge for the services you receive. Patients are required to pay for services at the time treatment is provided.

The School accepts cash, debit cards, all major credit cards (Visa, MasterCard, Discover and American Express) and most dental insurance plans. Our Patient Services staff will assist you in processing your insurance claims. A contractual payment plan can be arranged with a minimal down payment and monthly installments.

Student clinic fees are generally lower than private practice. Treatment is provided with personal attention and supervision, however, students will take significantly longer than a private dental practice.

Location and Parking

The School of Dentistry entrance is located at 452 E. Muhammad Ali Blvd. on the University of Louisville Health Sciences Campus. The School is located on TARC bus lines, providing easy accessibility.

Patient pay parking is located inside the UofL Health Care Outpatient Center parking structure located at 414 E Chestnut St. Limited metered street parking is located on Muhammad Ali, Preston, and Chestnut Streets. The School is handicap accessible, and limited handicapped parking is available near the entrance.

To better serve our patients, the School of Dentistry provides a free shuttle service for pick up and drop off from the Chestnut street parking garage and the School of Dentistry patient entrance. The UofL shuttle runs approximately every 15 minutes. We hope this will assist in your visit to the school!

Advanced Education Programs

Please ask for a one-hour parking voucher from the main entrance receptionist.

Advanced Education Programs

Advanced Education programs are offered at the School of Dentistry to resident dentists. Residents have already graduated from Dental School and are continuing their education in a specialized field. Fees for services provided by resident dentists are generally about 20% less than those in a private dental practice.

Special Patient Situations

The School of Dentistry offers a variety of programs and services to accommodate most patient needs. For patients with complex treatment needs, or for whom time is a concern, care is available at a slightly higher fee in the following Advanced Education Programs:

Endodontics: 502-852-5677
General Practice: 502-852-7660
Oral Surgery: 502-852-7660
Orthodontics: 502-852-5625
Pediatric Dentistry: 502-852-5642
Periodontics: 502-852-5100
Prosthodontics: 502-852-3482

FACULTY PRACTICE

For patients interested in being treated by ULSD Faculty, you may call:
University of Louisville Dental Associates
502-852-5401.

Community Health Clinics and How to Find a Dentist

Sometimes treatment is too complex for dental students to perform or manage. In these cases, patients are referred to private practice. Below are a number of local resources to find a dentist:

Find a Dentist (online)	Community Health Clinics (Reduced Services):
American Dental Association: www.mouthhealthy.org/en/find-a-dentist/	Family Health Centers Portland Dental Office: (502) 772-8160
Kentucky Dental Association: www.kyda.org/find-a-dentist.html	Park Duvalle Community Health Center: (502) 774-4401
Indiana Dental Association: http://www.indental.org/Find-a-Dentist	

University of Louisville School of Dentistry
501 S. Preston Street
Louisville, KY 40202
(502) 852-5096
Visit us on the web at
Louisville.edu/dentistry

Welcome!

The University of Louisville School of Dentistry (ULSD) wishes to extend a warm welcome to you! We appreciate the confidence and trust you have placed in us by asking for a new patient evaluation appointment.

> **Your new patient appointment will be scheduled and sent on an appointment card. You may also call the school to check the time of your appointment. Please plan to arrive 30 minutes prior to your scheduled appointment to ensure adequate time for parking and completion of additional paper work. A preview of new patient paperwork is provided at the end of this letter. You are not required to complete it prior to your arrival, as all signatures will be recorded electronically when you check in. It can be beneficial to complete the Health History Form prior to your arrival, to save time.**

As a school, we strive to ensure our students become responsible professionals. As a patient of the School of Dentistry you agree to help ULSD provide our students the opportunity to deliver quality, patient-centered, oral health care with compassion and respect.

The School requests that all new patients be scheduled for a new patient evaluation appointment. The evaluation appointment will take approximately 90 minutes. At this first visit, the School will have the opportunity to assess your dental needs, address any health concerns and make the determination if your dental needs can be met by dental students. The School may request additional information from your medical doctor(s) before making that decision. Medical consultations take time to send and receive back the information requested. Depending upon your medical and dental needs, there may be times, except in emergency cases, when dental treatment can only begin after a medical consultation has been received. Patients may be assigned to either the student dentist or the graduate/specialty care program depending upon the above mentioned considerations.

The cost of this new patient evaluation appointment is $52. The $52 covers the cost of one x-ray (panoramic film). If you do not become a patient of the School, the $52 is not refunded, but you may request a copy of the panoramic film. ULSD accepts cash, Visa, MasterCard, Discover and American Express payments for the first visit.

After the New Patient Evaluation
If a determination is made that your needs match with a program at the School, then you will be given information about the appropriate program. You may match with either the student dentist or the graduate/specialty care program. Cost for dental treatment in a graduate program is higher than in the student dentist program. Although the School understands that cost may be a factor, the decision on your assignment is based on the complexity of your dental needs and your overall medical history. All major insurances are accepted and an interest-free payment plan is available.

Your Health History
Enclosed is a health history form. Please bring this completed form, a list of any medications you are taking and the name and phone number(s) of your medical doctor(s) along with this letter with you to your evaluation appointment. **If you have radiographs, either digital or film-based, please provide copies prior to your appointment. Digital radiographs of high-quality are preferred; however, all formats are accepted. Mail copies to: Records Room, School of Dentistry, University of Louisville, Louisville, KY 40292-0001**

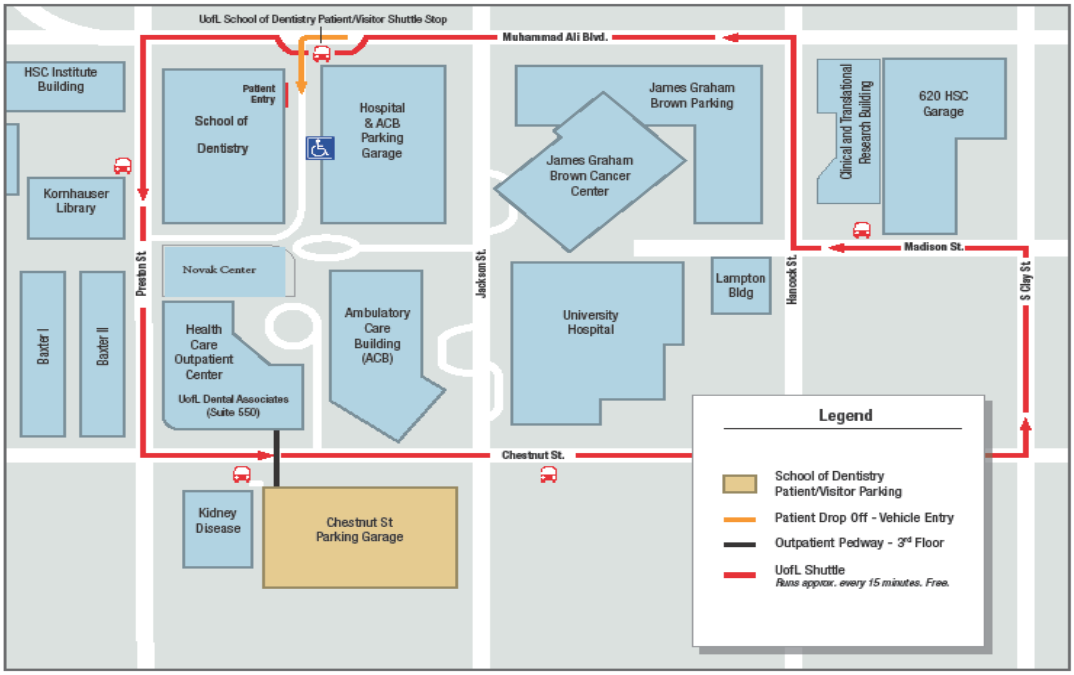
Directions and Parking
If you are in need of wheel chair assistance, translation services, or other special accommodations, please call **(502) 852-5096** ***prior*** to your appointment.

The School of Dentistry allows for patient/visitor drop-off at the front entryway. ***Please note that on Wednesday, February 22, 2017, the vehicular entrance for the School of Dentistry changed to 452 E. Muhammad Ali Blvd., Louisville, KY 40202.*** If patient drop-off is desired, please enter by turning left from Muhammad Ali Blvd. There are parking spaces by the entryway for those requiring accommodations. Please be sure to have a decal on display, as you can be fined $200 if one is not present. A parking garage is located on Chestnut Street just east of the Preston Street – Chestnut Street intersection for all other parking.

To better serve visitors to the School of Dentistry, the UofL shuttle will now make two additional stops as part of its regular route; one just to the left as you exit the first floor of the Chestnut St. Parking Garage and the second along Muhammad Ali Blvd. near the front entrance of the School of Dentistry. The UofL shuttle is free and runs approximately every 15 minutes. We hope this will assist in your visit to the school!

Parking meters (short term) are located all around the School of Dentistry at $0.25 per 12 minutes. Limited metered parking spaces are located on both Muhammad Ali and Preston Streets. Parking meters require quarters (no change is available from school staff). Please ensure that you have adequate time on the meter to avoid receiving a ticket. Use of parking meters is not recommended for long visits to the school. After your appointment, please check with the person at the School of Dentistry front desk for a receipt that allows for $2 off of the garage parking fee.

If you wish to use http://maps.google.com for directions from your home, ***the vehicular entrance for the School of Dentistry has changed to 452 E. Muhammad Ali Blvd., Louisville, KY 40202.*** The street address of the Chestnut Street Parking Garage (Health Care Outpatient Center) is 414 E. Chestnut St., Louisville, KY 40202. Additional information regarding location and accessibility can be found online at http://louisville.edu/dentistry/patient-care/appointment/directions.



From the South:

1. Take I-65 North to Exit 136A, Broadway/Chestnut Street. This ramp exits onto Brook Street.
2. Continue north on Brook Street for two blocks.
3. Turn right on East Chestnut Street.
4. Continue two blocks, parking garage is on the right (414 E Chestnut St).

From the North:

1. Take I-65 South to Exit 136C, Jefferson Street Downtown.
2. Stay in the far left lane of the ramp for Brook Street.
3. Proceed to the second traffic light to East Market and turn right.
4. Go two blocks to South Preston Street and turn right.
5. Continue four blocks south on South Preston Street to reach East Chestnut Street.
6. Turn left on East Chestnut Street, parking garage is on the right (414 E Chestnut St).

From the East or West:

1. Take I-64 or I-71 to I-65 South.
2. Follow the directions above

University of Louisville School of Dentistry | Health History Form

Patient Information

Last Name First Name Middle Name		
Address		Preferred Name:
City, State Zip		Gender:
Social Security #:	Date of Birth:	Age:
Ethnicity: □American Indian/Alaskan □Asian/Pacific Islander □Black, non-Hispanic □Hispanic □Multiracial □White, non-Hispanic □Other □Choose not to Answer		
Phone: Home	Work	Other

What is the reason for your dental visit today?

Have you experienced or had contact with someone with any of the following symptoms: Fever >101.5ºF (38.6ºC), severe headache, muscle pain, weakness, diarrhea, vomiting, abdominal (stomach) pain, lack of appetite? ☐Yes ☐No (Please circle symptoms)

Have you or someone you have had contact with recently traveled outside the United States? ☐Yes ☐No
If yes, where? _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, list condition(s) you are being treated for:

Have you had a serious illness, operation or been hospitalized overnight in the past 5 years? ☐ Yes ☐ No
If yes, what was the illness or problem?

List all drugs, medications of any kind you are taking including any vitamins, natural or herbal preparations and/or diet supplements:

Have you had an orthopedic total (artificial) joint (hip, knee, elbow, finger) replacement?
☐Yes ☐No If yes, date of surgery _____/_____/_____
Have you had any complications? ☐Yes ☐No

Have you ever taken (or are scheduled to start taking) anti-osteoporosis/bisphosphonate drugs such as Aredia, Zometa, Fosomax, Actonel, Boniva, Reclast, Didronel, Prolia, Xgeva or Skelid?
☐Yes ☐No If yes, date treatment began:_____/_____/_____

Are you allergic to, or have had a reaction to:

Local anesthetics (Novocain)?	☐Yes ☐No	Penicillin or other antibiotics?	☐Yes ☐No
Aspirin or ibuprofen (Motrin)?	☐Yes ☐No	Codeine or other narcotics?	☐Yes ☐No
Latex (rubber)?	☐Yes ☐No	Metals (nickel, silver, etc.)?	☐Yes ☐No

Any other drug or medication (please list):

Do you have any special needs/accommodations?

☐ Blind/ Visually impaired	☐ Require American Sign Language (ASL)
☐ Deaf/ hearing impaired	☐ Do you need help understanding English?
☐ Require wheelchair	Which language do you prefer?_____

University of Louisville School of Dentistry | Health History Form

Please check your response to indicate if you have any of the following diseases or problems:

Heart attack	☐Yes ☐No	Kidney disease/kidney failure/ dialysis	☐Yes ☐No
Angina/chest pains or exertion	☐Yes ☐No	Asthma	☐Yes ☐No
Heart failure or enlarged heart	☐Yes ☐No	Emphysema or chronic bronchitis	☐Yes ☐No
Arrhythmia/irregular heartbeat	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Hypertension/high blood pressure	☐Yes ☐No	Been exposed to anyone with tuberculosis	☐Yes ☐No
Endocarditis	☐Yes ☐No	Persistent cough for longer than 3 weeks	☐Yes ☐No
Congenital heart defect	☐Yes ☐No	Cough that produces blood	☐Yes ☐No
Artificial (prosthetic) heart valve	☐Yes ☐No	Fever, chills, night sweats	☐Yes ☐No
Heart pacemaker/defibrillator	☐Yes ☐No	Autoimmune disease/Rheumatoid arthritis	☐Yes ☐No
Heart transplant	☐Yes ☐No	Cancer/Chemotherapy/Radiation treatment	☐Yes ☐No
Anemia	☐Yes ☐No	Organ, bone marrow, or stem cell transplant	☐Yes ☐No
Sickle cell anemia/disease	☐Yes ☐No	HIV-positive or AIDS	☐Yes ☐No
Hemophilia	☐Yes ☐No	Sexually transmitted disease	☐Yes ☐No
Leukemia or lymphoma	☐Yes ☐No	Tobacco smoking	☐Yes ☐No
Tendency to bleed longer than normal	☐Yes ☐No	Alcohol or drug addiction	☐Yes ☐No
Stroke or transient ischemic attack (TIA)	☐Yes ☐No	Recreational drug use	☐Yes ☐No
Epilepsy, seizures or convulsions	☐Yes ☐No	Dementia/Alzheimer's	☐Yes ☐No
Thyroid disease	☐Yes ☐No	Cerebral palsy	☐Yes ☐No
Diabetes	☐Yes ☐No	Autism/Intellectually challenged	☐Yes ☐No
Stomach or intestinal ulcers	☐Yes ☐No	**WOMEN ONLY:**	
Gastritis or esophageal reflux	☐Yes ☐No	Pregnant?	☐Yes ☐No
Gastrointestinal disease	☐Yes ☐No	Taking birth control pills?	☐Yes ☐No
Hepatitis or yellow jaundice	☐Yes ☐No	Nursing?	☐Yes ☐No
Liver disease or cirrhosis	☐Yes ☐No		

DO YOU HAVE ANY OTHER DISEASE, MEDICAL CONDITION, OR PROBLEM NOT LISTED ON THIS FORM? ☐Yes ☐No

If yes, then please list below:

_____

_____

_____

Patient Number:_____

UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE TELLS YOU HOW YOUR MEDICAL RECORD MAY BE USED AND SHARED AND HOW YOU MAY GET THIS INFORMATION.

PLEASE READ IT CAREFULLY.

OUR PLEDGE TO YOU

Your health information is something that the **UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY** has always worked to keep private. We also are ethically and legally bound to keep it confidential under state and federal laws.

WHAT IS THIS DOCUMENT?

This document, called a Notice of Privacy Practices, tells you how we may use and share your health information. This includes using and sharing it so that we may provide you with health care and be paid for it, and so that we may run our business and follow state and federal legal rules. We must follow the terms of this notice.

WHO FOLLOWS THIS NOTICE

This notice is for UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY. Other separate health care providers at the University of Louisville Medical Center also may provide you with health services. You might receive a notice of privacy practices from them, too. If you are seen in a hospital at the UofL Medical Center, it will give you a notice that covers medical information gathered during your visit there including the information created by the **UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY**.

WAYS WE MAY USE AND SHARE YOUR HEALTH INFORMATION WITHOUT YOUR PERMISSION.

Treatment. We will use and share your medical record for your care.

Example: Doctors, dentists, students, medical residents or other university workers may read your record to learn if a treatment is working.

Your medical information also may be shared with doctors or dentists outside the **UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY** to decide the best treatment for you.

Payment. We may use and share your medical information to be paid for the care and services we provided you.

Examples: We may contact your insurance company to learn if a service is covered. We may bill you or your insurance company for the services we provide.

Health Care Operations. We need to use and share your health information to run our health care business. We may use or share your information for several reasons.

Examples: Our staff may use your medical information to make sure that you and other patients get the best possible care. Medical students may see the information as part of their training. Others on our staff may use it to make sure that billing is being done correctly. In certain special conditions, other health care providers may get your information from us to run their businesses.

Business Associates. We may share your medical information with another company or organization, called a “business associate,” that we hire to provide a service to us or on our behalf.

Example: We may share your information with a company that provides transcription or dictation services for our health care providers.

Health-Related Benefits, Services and Treatment Alternatives. We may tell you about interesting health-related benefits or services

such as newsletters, announcements, possible treatments or alternatives.

Fundraising Activities. The UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY relies on the kindness of the community to help us provide quality health care to this region. *Patients who share their experiences and suggest ways to work with us are giving back in a meaningful way.* Their information also helps us improve and expand our services. We may use or share limited information about you to ask for your help in supporting special projects or services. Your generosity helps us continue to be an outstanding provider of health care services in this region. You can ask to not be contacted for fundraising purposes.

Required Disclosures. If the Secretary of the Department of Health and Human Services requests your health information to investigate a possible HIPAA violation, we must share your information with the Secretary. Under the same laws, we must give you information in your medical record. We are allowed to keep some information from you.

Required by Law. We must share medical information if federal, state or local law says so.

Public Health and Safety. We may share your medical information for public health reasons. Examples include:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report information to the FDA about the products it oversees;
- to let you know that you may have been exposed to a disease or may be at risk for getting or spreading a disease or condition; or
- to your employer in certain limited instances.

Abuse and Neglect. The law may require us to report suspected abuse, neglect or domestic violence to state and federal agencies. Your information may be shared with these agencies for this purpose. Generally, you will be told that we are sharing this information with these agencies.

Health Oversight Activities. Certain health agencies are in charge of overseeing health care systems and government programs or to make sure that civil rights laws are being followed. We may share your information with these agencies for these purposes.

Legal Proceedings. If a court or administrative authority orders us to do so, we may release your health records. We will only share the information required by the order. If we receive any other legal request, we may also release your health record. However, for other requests, we will only release the information if we are told that you know about it, had a chance to object and did not.

Law Enforcement. We may share health information if a law enforcement official asks for it:

- to respond to a court order, warrant, summons or other similar process;
- to identify or locate a suspect, fugitive, material witness or missing person; or
- to obtain information about an actual or suspected victim of a crime.

We may share information with a law enforcement official:

- if we believe a death was the result of a crime;
- to report crimes on our property; or
- in an emergency.

Coroners, Medical Examiners and Funeral Directors. We may share health information with a coroner or medical examiner to identify a dead person or find the cause of death. We also may release health information to funeral directors if they need it to do their job.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to the organizations in charge of getting, transporting or transplanting an organ, eye or tissue.

Research. We may share your medical record with researchers, without your permission, in very limited situations. In most cases, a researcher must submit his/her request to see your information to a special group called the Institutional Review Board (“IRB”). This group will decide if it should allow the researcher to use or share your information. Your medical information also may be used by or shared with researchers to prepare for research, but only under strict conditions. Under similar strict

conditions, medical information about dead people can be used or shared.

To Prevent a Serious Threat to Safety. We may use and share your medical information to prevent a serious threat to your health and safety or the health and safety of others.

Special Governmental Functions. We may share your medical information with:

Authorized federal officials

- for intelligence, counter-intelligence and other national security activities authorized by law; or
- to protect the President.

Armed forces command authorities or the Department of Veterans Affairs

- to see if you are fit for military duty or eligible for veterans health services; or
- to see if you are medically fit to receive a security clearance by the Department of State.

Correctional facility or law enforcement official or agency if you are an inmate or under the custody of a law enforcement official or agency, if necessary, to:

- help the correctional facility provide you with health care; or
- protect the health and safety of you and/or others.

Workers' Compensation. We may share your health information with agencies or individuals to follow workers' compensation laws or other similar programs.

WAYS WE MAY USE AND SHARE YOUR HEALTH INFORMATION WHEN WE HAVE GIVEN YOU A CHANCE TO OBJECT.

Individuals Involved in Your Care or Payment for Your Care. We may share medical information about you with your family members, friends or any other person you tell us who is involved in your medical care or who helps pay for it.

We may tell your family or friends your condition and that you are in one of our facilities. We also may share medical information about you to a disaster relief agency so that your family can be told of your condition and location.

Usually you will have a chance to object to the sharing of this information. If you are unable to agree or object to the sharing of your information, we may share the information as necessary if we determine that it is in your best interest based on our professional judgment.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have certain rights regarding your health information, as described below. These rights apply to the health information we keep. You must submit a written request to use any of these rights. You can send your written request to the **UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY'S Privacy Officer at 501 S. Preston Street, Room 229, Louisville, KY 40202.**

Right to Request Special Communications. You have the right to ask us to contact you about medical matters in a certain way or at a certain place. We will follow all reasonable requests. Your request must tell us how you wish to be contacted.

Right to Inspect and Copy. You have the right to read or get a copy of your health information, with some exceptions. We may turn down your request under certain circumstances. If we do so, you may ask for a licensed health care professional chosen by us to review why we turned you down. We will follow the reviewer's decision.

Right to Request Changes. If you believe the health information that we created is wrong or incomplete, you may ask us to change it. *You must provide a reason why you want the change*. We are not required to agree to make the change. If we do not agree, we will send you a letter saying why we will not make the change. You may then send us another letter disagreeing with us. We cannot take out or destroy any information already in your medical record, but the letters will be attached to the information you wanted changed or corrected.

Right to an Accounting of Disclosures. We are required to track who we share your health information with under certain circumstances. You have the right to ask for a copy of this list. We do not have to track every time we share your health information with others. *Your request must give a time period, which may not be longer than 6 years.*

Right to Request Restrictions. You have the right to ask for a restriction or limitation on the medical information we use or share about you for payment, treatment or health care operations and the information we may share with your family, friends or others involved in your care. We are not required to agree to your request, except as noted below. If we agree, we will follow your request unless the information is needed to provide you with emergency treatment. You must tell us the type of restriction you want and to whom it applies.

There is one exception where we must agree to your request: You may ask us not to share specific information with your health insurance company.

To do this, you must pay for the specific health care completely out of your own pocket.

Right to Receive Notification if your Information is Breached. In many instances, you have the right to know if your unsecured information has been lost, stolen or otherwise seen by people who do not usually have the right to see it.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. Copies of this notice will be posted and available at each location where medical services are provided.

WAYS WE MAY USE AND SHARE YOUR HEALTH INFORMATION WITH YOUR PERMISSION

Other uses and sharing of your health information that are not described in this notice will be made only with your written permission, called an Authorization. Examples where your Authorization is required include:

- Most uses or sharing of psychotherapy notes
- Using or sharing your health information for marketing purposes
- For some situations in which we get paid for sharing your information
-

You can revoke your Authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any sharing of information made with your Authorization before it was revoked.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for your health information we already have as well as any we get in the future. The revised notice also will be available at any of the locations where the **UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY** offers services.

IF YOU HAVE QUESTIONS OR NEED TO REPORT A PROBLEM

If you have any questions about this notice or about how your health information is used or shared by us please contact the University of Louisville Privacy Office by email at privacy@louisville.edu or by calling 502-852-3803.

If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint, please contact the University of Louisville Privacy Office at privacy@louisville.edu or write to Privacy Officer, University of Louisville Privacy Office, Med Center One Suite110, 501 E Broadway, Louisville, KY 40202. Please give as much information as possible so that the complaint can be looked into properly.

You may also file a complaint with the Secretary of the Department of Health and Human Services.

Your care will not be affected if you file a complaint, nor will any action be taken against you.

Acknowledgment by Patient or Personal Representative of Receipt of Notice of Privacy Practices

I acknowledge receiving a copy of the Notice of Privacy Practices given to me by University of Louisville School of Dentistry ("ULSD).

I understand this Notice explains how ULSD is permitted to Use and Disclose my Protected Health Information and how ULSD must protect the confidentiality of my health information.

I understand I should keep the Notice and refer to it if I have questions. I also understand I should call the ULSD Privacy Officer at (502) 852-0002 if I have a question or concern about my privacy rights.

_____
Print name of Patient

_____
(If applicable) Print name of Patient's Personal Representative and Relationship to Patient

_____
Signature by Patient or Patient's Personal Representative

_____
Date

OFFICE STAFF USE ONLY IF ACKNOWLEDGMENT NOT SIGNED

The following attempt(s) were made to obtain a written Acknowledgment of Receipt:

☐ NPP given to Patient, who refused to sign.

☐ NPP was mailed to Patient's home address as stated in records.

☐ NPP was mailed to an alternate address, at Patient's request.

☐ NPP was faxed or emailed to Patient, at Patient's request.

Other reason(s) why written acknowledgment not obtained: _____

_____

_____

_____ _____
Signature of Person attempting to obtain signed Acknowledgment Date

ORIGINAL MAINTAINED IN FILE

UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY
GENERAL CONSENT FORM - FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

1) I hereby consent to the performance of a course of dental treatment procedures, deemed necessary and desirable for any condition found on examination, or any dental treatment or procedures which may later become apparent during treatment. This consent shall extend to all treatments, services, medications and operations upon the teeth and jaws as may be necessary to correct oral deficiency, abnormality and/or infection. I consent to the administration of anesthetic agents for my dental treatment. I acknowledge that no guarantee or assurance is made as to the results that may be obtained. I further consent that the authorities of this facility may dispose of any tissues or parts which it may be necessary to remove.

2) I hereby consent to treatment by University of Louisville dental and dental hygiene students and/or faculty or staff, in accordance with ordinary practices of the School of Dentistry facilities.

3) I have been asked and agree to the taking of pictures either by digital camera and/or by the use of closed-circuit television (including motion pictures). I understand that my photographs, videotapes, digital or other images may be used to assist with my identification, diagnosis and treatment, the payment of my bill, and for educational purposes within the School. Other than for treatment, payment and healthcare operations, images that could be used to identify me will NOT be released outside of the School without a signed authorization.

4) I understand that the School uses Standard Precautions (the highest level recommended by the CDC) for infection control protocol. I understand that in the event of an occupational blood exposure to a student/faculty/staff, I may be asked to be tested for Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus (HIV).

5) I understand that this facility operates on a *fee-for-service* basis and that fees are payable at the time of service. I understand that the established fees will be charged for services rendered and that quotes and/or estimates of costs for planned treatment are only binding if associated with a signed approved treatment plan that reflects the accurate established fees for the planned procedures. I authorize the School to release any information and records concerning my treatment as may be necessary to process insurance claims or payment for the care and treatment provided. I assign to the School of Dentistry all dental and medical insurance benefits applicable and authorize my insurer or third party payment program to tender payment of such amounts directly to the School of Dentistry.

6) If I provide a telephone number or email address, I consent to receive calls, text messages, or electronic mail, including, but not limited to, messages about appointments, treatment, billing, and payment for items and services. Messages may be prerecorded or artificial voice messages and may use automatic dialing devices or any other form of electronic or voice communication. I may cancel this consent by notifying the School in writing.

7) ❑ Patient Rights: I received a copy of the University of Louisville School of Dentistry's Patient Rights and Responsibilities.
❑ I declined to take a copy of the Patient Rights offered.

8) ❑ Privacy Notice: I have been provided and accepted the University of Louisville School of Dentistry's Notice of Privacy Practices.
❑ I declined to accept the provided Privacy Notice.

9) Insurance Benefits: I have provided the University of Louisville School of Dentistry my insurance information so the School may process my insurance claims as a courtesy to me. I understand and agree to pay all co-payments and/or deductibles in accordance with my insurance plan. I also understand that most insurance plans do not pay for all costs connected with my treatment and that it is my responsibility to determine my insurance plan coverage. I understand and agree that I am responsible for ALL dental school charges and professional fees for services and supplies that are not covered by insurance.

❑ No insurance information provided

❑ Kentucky Medicaid participant: I understand that if I agree to treatment not covered by Medicaid, I will be asked to accept financial responsibility for the costs before treatment can begin.

10) I certify that I have read and fully understand the general consent form, and understand and accept responsibility for payment of services provided.

SIGNATURE OF PATIENT/PERSONAL REPRESENTATIVE _____ Date _____

ULSD Representative _____ Date _____

UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY
APPOINTMENT OF PERSONAL REPRESENTATIVE/INDIVIDUALS INVOLVED IN CARE TO RECEIVE PROTECTED HEALTH INFORMATION

You may rely upon your spouse, relatives or friends from time to time to understand your treatment options, visit your health care providers, acquire prescriptions, get test results, and otherwise be involved in your medical care. However, federal law does not allow us to disclose any of this information to these people unless you appoint them as your "personal representatives."

The School may share medical information about you with your family members, friends or any other persons you tell us who are involved in your dental care or who help pay for your dental care.

These individuals may: (please check all that apply)

□ Make/verify appointments □ Discuss financial matters □ Receive messages

□ Discuss treatment options □ Pick up requested information

□ Bring my minor child to their appointments: *[Generally, minor children must be accompanied by a parent and/or legal guardian. However, children between the ages of 13-17, with a signed treatment plan (tx plan signed by parent/guardian) may continue non-invasive treatment without a parent being present. In an emergency situation, consent for treatment may be granted by phone as time allows.]*

List all individuals who may be involved in your care and/or the care of your minor child. Please note that you can add and/or remove individuals at any time.

Name of individuals	Contact Phone Number

Is someone other than the patient signing this form? □ Yes □ No

If yes, what is the relationship to the patient? _____

I may revoke this appointment at any time. My revocation will NOT affect any actions that have been already taken in reliance on my original appointment.

_____ Date:_____
Patient's Printed Name

_____
Patient's Signature

Patient's Address: _____
_____
_____