"KATY ON THE GO"

SCHOOL BASED DENTAL PROGRAM

The Knob Noster school district and Katy Trail Community Health are excited to announce they have joined together to offer a *School Based Dental Program*. This program will provide your child an opportunity to receive dental services at school during normal school hours. Katy Trail owns and operates a mobile dental unit which we proudly call "Katy on the Go". Katy Trail will be bringing state of the art dental care services to students in the most comfortable, convenient, and effective way possible.

We offer comprehensive dental care. Our services will include cleanings, X-Rays, examinations, fillings, some crowns and extractions. There may be some procedures that cannot be completed on the mobile unit and it may be necessary to refer those patients to either our Sedalia or Warsaw clinic.

The program will serve all Missouri Medicaid students. Missouri Medicaid programs included are MoHealthNet, MissouriCare, Aetna and Home State Health Plan. There is no cost or financial requirement to the parent if the student is covered by Missouri Medicaid. If the child is uninsured, Katy Trail staff will work with the parents/guardian to get them approved for Missouri Medicaid. If the child is insured, we accept most dental insurance.

Students must have a consent form signed by their parent/guardian and turned in to the school nurse before being seen at "Katy on the Go". Attached is the new patient packet, which needs to be returned to the school nurse no later than February 19th, 2016. The program at your school is scheduled for February 29th, 2016.

If there are any questions about our services, please contact either Mendy Hohenfeldt, Katy Trail Dental Clinic Site Manager at 660-826-4774 ext 862 or Holly Buso, Katy Trail Dental Clinic Coordinator at 660-826-4774 ext 867.

We look forward to working with you and your child!

REQUIRED INFORMATION FOR DENTAL SERVICES

PATIENT NAME: ______________________________ *DOB:* ______________ *Chart #:* _______________

Medical Primary Care Provider: ______________________________________ *Today's Date* ____________

Office Use Only:

Weight: __________________ *Height:* ____________ *B/P:* _______________ *Pulse:* ____________
(New & Recall Only) *(New & Recall Only)* *(Every Visit- over age 3)* *(Every Visit- over age 3)*

Tobacco Usage: ❒ Never smoked tobacco ❒ Daily tobacco user ❒ Ex-smoker

Have you ever been diagnosed with, or treated for any of the following? (Check all that apply):

- ❒ Abnormal bleeding
- ❒ ADHD
- ❒ Artificial Heart Valves
- ❒ Artificial Bones/ Joints
- ❒ Asthma
- ❒ Autism- mild/severe
- ❒ Behavioral Issues
- ❒ Cancer
- ❒ Congenital Heart Defects
- ❒ Diabetes (Oral Meds)
- ❒ Diabetes (Insulin)
- ❒ Tuberculosis
- ❒ Emphysema
- ❒ Hyperlipidemia
- ❒ Other: ______________________________
- ❒ Epilepsy
- ❒ Fainting Spells
- ❒ Scarlet Fever
- ❒ Shortness of Breath
- ❒ Heart Attack
- ❒ Heart Murmur
- ❒ Heart Disease
- ❒ Mitral Valve Prolapse
- ❒ Hemophilia
- ❒ Glaucoma
- ❒ HIV/AIDS
- ❒ Kidney Problems
- ❒ Psychiatric Problems
- ❒ Obesity
- ❒ Hypertension (high blood pressure)
- ❒ Hypotension (low blood pressure)
- ❒ Coronary Artery Disease (CAD)
- ❒ Non- Epileptic Seizures
- ❒ Lupus
- ❒ Rheumatic Fever
- ❒ Anxiety Attacks
- ❒ Tobacco User (smoke or smokeless)
- ❒ Drug Abuse
- ❒ Alcohol Abuse
- ❒ Hepatitis A
- ❒ Hepatitis B
- ❒ Hepatitis C
- ❒ Other: ____________________

❒ Currently Pregnant, Due Date: ____________________ ❒ Currently Nursing

Office Use Only: *Enter in tooth chart under Medical Alerts*

Are you currently taking any medications? (List any medications that you are currently taking):

____

____

____

❒ *Not currently taking any medications*

Office Use Only: *Enter in tooth chart under Medication/ Prescription. If not there, select "New" and enter.*

Are you allergic to LATEX? _________ ***If yes, what kind of reaction?*** ____________________

Office Use Only: *If yes----- Enter in tooth chart under allergies AND create "pop-up" note*

Enter any Drug/Food Allergies	***What Type of Reaction?***	***Office Use Only:***
1.		*Enter in tooth chart under "Allergies". Select specific allergy & specific reaction. If not an option, select "New" and enter.*
2.		
3.		
4.		

❒ *No Known Drug/Food/Environmental Allergies*

Have you had any recent hospitalizations? ❒ No ❒ Yes- Date of hospitalization: ______________

If yes, please explain: ____

Katy Trail Community Health

PATIENT REGISTRATION FORM

(Please Print)

Today's Date:	KTCH Medical Provider:	KTCH Dental Provider:

PATIENT INFORMATION

Patient's First Name: Middle Initial: Last Name:	Social Security Number:	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Street Address:	City:	State:	Zip Code:	
Mailing Address: ❑ Same as above	Homeless Status: ❑ Doubling Up ❑ Homeless Shelter ❑ Homeless ❑ Other: _______________			
Email Address:	Home Phone Number: ( )	Cell Phone Number: ( )	Work Phone Number: ( )	
Does the patient have any problems with: ❑ Vision ❑ Hearing ❑ Reading ❑ Speaking Explain:	Phone Number for Appointment Reminder Calls:			
Preferred Pharmacy:	Preferred Pharmacy City & Street:			

BILLING INFORMATION

Person responsible for bill:	Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Step Child ❑ Other:	Birth date: / /
Address (Street, City, State, Zip): ❑ Same as Patient		Primary Phone Number: ( )
Occupation:	Employer:	Employer Phone Number:

MEDICAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Name of Primary Medical Insurance:	Subscribers Name:		Subscriber's SSN:
	Policy #:	Group #:	Subscriber's Birth Date: / /
	Subscriber's Address: ❑ Same as Patient		Subscriber's Phone #: ❑ Same as Patient

Patient's relationship to **primary medical insurance** subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Step Child ❑ Other:

Name of Secondary Insurance (if applicable):	Subscribers Name:		Subscriber's SSN:
	Policy #:	Group #:	Subscriber's Birth Date: / /
	Subscriber's Address: ❑ Same as Patient		Subscriber's Phone #: ❑ Same as Patient

Patients relationship to **secondary medical insurance** subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Step Child ❑ Other

DENTAL INSURANCE INFORMATION

Name of Primary Dental Insurance:	Subscribers Name:		Subscriber's SSN:
	Policy #:	Group #:	Subscriber's Birth Date: / /
	Subscriber's Address: ❑ Same as Patient		Subscriber's Phone #: ❑ Same as Patient

Patients relationship to **primary dental insurance** subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Step Child ❑ Other

Ethnicity:
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Not Reported/Refuse to Report

Race:
- ❑ Asian
- ❑ Native Hawaiian
- ❑ Other Pacific Islander
- ❑ Black/African American
- ❑ American Indian/Alaska Native
- ❑ White (not Hispanic or Latino)
- ❑ Hispanic or Latino (all races)
- ❑ More than one race
- ❑ Not Reported/Refuse to Report

Employment Status:

Parent or Guardian Employment:
❑ Full Time ❑ N/A
❑ Part Time

Are you a veteran?
❑ YES ❑ NO

Are you a current student?
❑ Full Time ❑ None
❑ Part Time

Highest Level of Education:
- ❑ 1-Not yet in school
- ❑ 2-Pre-School/Kindergarten
- ❑ 3-Grade School
- ❑ 4-Middle School
- ❑ 5-High School (Currently)
- ❑ 6-High School Grad/GED
- ❑ 7-Did Not Complete High School
- ❑ 8-Technical/Trade School
- ❑ 9-Some College
- ❑ 99-College Graduate

Patient Self Determination Act:

I have an advance directive:
❑ YES ❑ NO

How did you hear about us?
- ❑ Friends/Family
- ❑ TV
- ❑ Newspaper
- ❑ Radio
- ❑ Billboard
- ❑ Phonebook
- ❑ Drive By
- ❑ Website
- ❑ Outreach Event
- ❑ Employee
- ❑ Other Organization

Primary Language:
- ❑ English
- ❑ Spanish
- ❑ Russian
- ❑ Ukrainian
- ❑ Other:

Marital Status:
❑ Divorced ❑ Married ❑ Single
❑ Separated ❑ Widow

PARENT/LEGAL GUARDIAN OR SPOUSE INFORMATION	
The below information pertains to: ❑Parent(s) ❑Legal Guardian ❑Spouse	
Name:	Phone #: ( )
Address: ❑ Same as Patient	

PERSON(S) WHO MAY BE NOTIFIED IN CASES OF EMERGENCY OTHER THAN PARENT/LEGAL GUARDIAN			
Name:	Relationship to Patient:	Primary Phone #:	Secondary Phone #:

PERSON(S) WHO MAY ACCOMPANY MINOR AND MAKE DECISIONS FOR MEDICAL/DENTAL/MENTAL TREATMENT OTHER THAN PARENT/LEGAL GUARDIAN		
Name:	Relationship to Patient:	Phone #:
1.		
2.		
3.		

PERSON(S) WHO MAY OBTAIN MY MEDICAL AND/OR DENTAL HEALTH INFORMATION. THIS MAY INCLUDE VERBAL AND/OR COPIES OF RECORDS UNLESS SPECIFIED BY YOU.

*Please note that records specially protected by 42 CFR part 2 require a separate authorization for release and the below authorization will not suffice.

Name:	Relationship to Patient:	Phone:
1.		
2.		
3.		

All Patients:
I, undersigned, do consent for treatment as deemed necessary by the attending health care provider. I, the undersigned, do also consent to treatment by KTCH dental providers and/or students from UMKC school of dentistry and SFCC.

Initial here:

Insurance & Payment:
All charges are due at the time that services are rendered unless other arrangements have been made prior to the visit.

The above insurance information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Katy Trail Community Health. I understand that I am financially responsible for any balance.. I authorize Katy Trail Community Health to release any medical information necessary to process claims and further authorize payment of medical benefits payable directly to Katy Trail Community Health. I understand that Katy Trail Community Health will file and complete the necessary steps to collect my insurance payment. However, if my insurance doesn't respond or payment is not made within 90 days, I understand that it is my responsibility to pay for any services rendered by Katy Trail Community Health. I further understand that Katy Trail Community Health may not be contracted with my insurance plan and I agree that I am responsible for charges denied for such reasons

Initial here:

Consent for Treatment of Minor:
By signing this consent I represent that I have the legal responsibility for and authority to direct the medical treatment of the above patient, either as parent or legal guardian and I will hold harmless any attending physician or other person or entity against any claim that medical treatment provided to the above patient was not authorized. This consent includes this and subsequent office visits for which I bring this minor to this office. My permission also extends to releasing this medical record to consulting physicians if ever required to adequately diagnose and treat this minor.

Initial Here:

Receipt of Privacy Statement:
We are committed to protecting your personal health information in compliance with the law. By signing below you are acknowledging that you have read and agree with the KTCH privacy statement and understand that at any time upon request, you may obtain a copy of the KTCH Statement of Privacy Practices.

Initial Here:

By signing below I am acknowledging that I have completed the above information to the best of my knowledge. By signing below and initialing on the above lines, I am acknowledging that I have read and understand the above information.

SIGNATURE: ______________________________ **DATE:** ______________

By signing below I acknowledge that I am an employee of Katy Trail Community health and I have witnessed and can verify that the above signatures/initials are that of the patient/patient's legal representative.

WITNESS SIGNATURE: ______________________________ **DATE:** ______________

Prairie Hills
Katy Trail Community Health

821 Westwood Dr.
Sedalia, MO 65301

17571N. Dam Access Rd
Warsaw, MO 65355

112 State Hwy 5
Versailles, MO 65084

Dental Consent to Treat Patient Without Parent/Legal Guardian Present

Authorization:
I have the legal right to preauthorize Katy Trail Community Health and its personnel to deliver routine dental treatment and services to my child. Routine dental care may include, but is not limited to: dental examinations, prophylaxis (cleaning), fluoride treatment, x-rays and any other treatment plan as recommended.

I ______________________________(print parent/legal guardian name) request and authorize Katy Trail Community Health and its personnel to deliver routine dental care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:
Child's Name: ______________________________ DOB: ______________

Limitations:
Identify any specific limitations on the kinds of dental services/treatment for which this authorization is given.

____

____

______________________________ ______________________
Parent/Legal Guardian Name (print) Relationship to patient

______________________________ ______________________
Parent/Legal Guardian Signature Current Date

____
Contact Phone Number

Katy Trail Community Health

Prairie Hills
Katy Trail Community Health

Patient Rights

At Katy Trail Community Health, we are committed to providing you a **patient center medical home (PCMH)**. A patient centered medical home is not a place of residence and does not change where you live. Instead a medical home is where you get healthcare and see your primary care provider (PCP). A PCP can be a doctor, nurse practitioner or a dentist. Your PCP leads a team of individuals within the organization who, as a care team, will take responsibility for the ongoing care of each patient. You and your family are an essential part of the care team. As a patient, you have certain rights. Understanding those rights will help you to get the best possible care. You have the right to:

- ☑ Receive compassionate and respectful care regardless of age, sex, race, national origin, religion, disability, or communicable disease.
- ☑ Personal Provider – each patient has an ongoing relationship with a primary care provider (PCP) who will give complete and continuous care.
- ☑ Comprehensive Medical Care – the PCMH is responsible for meeting the majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. You have the right to be well informed about your diagnosis, treatment, and chances for recovery in words you can understand. This information should include the specific treatment, medical risks, benefits, side effects.
- ☑ Comprehensive Dental Care - the PCMH is responsible for meeting the majority of each patient's oral health care needs, including prevention and wellness and acute care. You have the right to be well informed about your diagnosis, treatment, and chances for recovery in words you can understand. This information should include the specific treatment, medical risks, benefits, side effects.
- ☑ Provider Directed Medical Practice – the PCP leads a team of individuals within the organization who, as care team, will take responsibility for the ongoing care of each patient. **Your care team includes your medical PCP, medical assistant, LPN, behavioral health consultant, care coordinator, and a case manager.** The care team will support the patient for self-management of their health and health care goals.
- ☑ Provider Directed Dental Practice - the PCP leads a team of individuals within the organization who, as care team, will take responsibility for the ongoing care of each patient. **Your care team includes your dental PCP, hygienist, dental assistant, expanded functions dental assistant, behavioral health consultant, and care coordinator.** The care team will support the patient for self-management of their oral health and oral health care goals.
- ☑ Whole Person Orientation – the PCP is responsible for providing for the entire patient's healthcare needs and takes responsibility for appropriately arranging care with other qualified professionals as needed.
- ☑ Care is Coordinated – the PCMH coordinates care across all areas of the health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital.
- ☑ Accessible Services – a PCMH delivers services that are easy to get and with shorter waiting times for urgent needs, better in-person hours, and around-the-clock telephone access to a member of the care team. **The after-hours phone number is 660-851-9012**
- ☑ Quality and Safety – PCMH's are dedicated to improving quality of care by using evidence-based medicine and clinical decision-making tools to help providers, patients and families make decisions. Patients will always have the right to refuse recommended treatment to the extent permitted by law, and to be told what will happen to you medically if that is your choice. Express verbally or by letter, any complaints or recommendations concerning our services. You may communicate a complaint or grievance in writing at our main site at 821 Westwood, Sedalia, MO 65301, or by calling our main site at 660-826-4774.
- ☑ Privacy – You have the right to the privacy and confidentiality of all your records pertaining to your treatment, except as required by law or third party payment. Your medical and dental record can be read only by individuals directly involved in or supervising your treatment, monitoring the quality of your treatment, or authorized by law or regulation. You have the right to access the information contained in your medical record, within the limit of the law and facility policy.

Patient Responsibilities

The care you receive is partially dependent upon your acting in a cooperative manner with your health care providers, including communicating openly and honestly, following treatment plans, and respecting the facility standards of conduct. As a patient at Katy Trail Community Health, you are responsible for:

1. Following all facility rules as posted inside and/or outside the clinical facility. Respecting and considering other people, employees, the property of others, and property of Katy Trail Community Health.
2. Advising us of any changes in the following:
   Name, Address, Phone Number(s), Insurance Information, Income, and Family Size
3. Providing accurate and complete information about current symptoms, medical history, hospitalizations, medications, care obtained outside the practice, self care information, advance directives, and any other matters related to care.
4. Following instructions that you and your care team have agreed upon. Follow through on goals for self-management of your health.
5. Asking questions about your care that you may not understand or have questions about, including risks of procedures, outcomes, and costs of treatment.
6. Knowing what medications or drugs you are taking, why you are taking them, and the proper way to take them according to your PCP's instructions.
7. Keeping scheduled appointments, arriving on time for scheduled appointments, and for calling at least 4 hours in advance to cancel when you cannot keep a scheduled appointment. KTCH reserves the right to terminate service to patients who do not show for appointments more than three times in a 12 month period.
   a. **MEDICAL**: <u>New patients are required to arrive 30 minutes in advance of their appointment.</u> Please notify us at least 4 hours in advance of appointment cancellations. After missing two consecutive medical/behavioral health appointments the patient will be placed in Same Day Only Appointments status. Patients may call each morning and be seen that day based on appointment availability for a same day appointment. After keeping a same day appointment the patient can once again schedule future appointments.
   b. **DENTAL:** <u>New patients are required to arrive 30 minutes in advance of their appointment.</u> If you are more than **10 minutes late for your dental appointment**, your appointment will be rescheduled. Please notify us at least 4 hours in advance of appointment cancellations. After missing two dental appointments the patient will be placed on a pending appointment list. The dental clinic will then call when an opening is available and after keeping this appointment the patient can once again schedule future appointments.
8. Attending and supervising your children while in the facility.
9. Calling your pharmacy to request a refill 1 week before you run out of your prescription. If authorized by a KTCH provider, your request will be filled within 72 business hours.
10. Paying bills and fees promptly as defined in the financial policies.

I have read and understand the Katy Trail Community Health **Patient Rights and Responsibilities** and have been given an opportunity to obtain a copy for my personal records.

______________________________ ____________________

Signature Date

<u>Katy Trail Community Health Medication Policy Acknowledgement</u>

1. We are concerned and do care about your pain. We do NOT, however, prescribe narcotics for chronic pain. We try to use all available methods, including referral, to treat pain <u>except</u> narcotics.

2. We generally do not prescribe benzodiazepams. This may include: Xanax (alprazolam), Ativan (lorazepam), Klonipin and Valium (diazepam). We recommend you see a Psychiatrist for these medications.

______________________________ ____________________

Signature Date

Katy Trail Community Health
Patient Financial Information

IMPORTANT NOTICE TO OUR PATIENTS-PLEASE READ CAREFULLY

- Our Sliding Fee Discount Program is designed to help you pay for medical, dental, and behavioral health services provided by KTCH. If you would like to apply for our sliding fee discount program, please ask the front desk for a sliding fee program application or request an appointment with one of our Care Coordinators. You must complete the application and provide proof of income to be certified for the sliding fee discount prior to any appointment that you would like the sliding fee to apply.

- Your child may be eligible for a Medicaid program so please ask for an appointment with one of our Care Coordinators to explore this option.

- Your payment today may be by cash, check, or credit / debit card. Your minimum co-pay is due at the time of check-in or your appointment will be rescheduled. The only exception will be when your medical/dental condition is considered an emergency which will be determined by our triage nurse/dental coordinator using guidelines established by our Chief Medical /Dental Officer.

- If you participate in a health insurance network, Katy Trail will be happy to file the insurance claim on your behalf. It is your responsibility to pay the balance of any fees for services not covered under your insurance plan upon receipt of the bill or as agreed upon in your payment plan. Should you foresee needing financial assistance to pay this balance; you must complete the sliding fee application and provide proof of income before the time of service to be certified for the slide at that time.

- If you do not participate in a health insurance network & have income over 200% of the poverty level, a deposit of $130 will be required for services you are receiving today. You will also receive a bill for any fees in excess of your deposit. Should the fees for medical service be less than your deposit, the difference will be refunded to you. It is your responsibility to pay the balance of any fees for services upon receipt of the bill or as agreed upon in your payment plan.

Katy Trail firmly believes that a good provider/patient relationship is based upon understanding and good communications. The above information was provided to avoid any misunderstandings. Questions about financial arrangements should be directed to our billing office at 1-877-733-5824 ext. 808. By signing below as the patient or other patient representative, you acknowledge that you have read this Patient Financial Information sheet and agree to the terms stated.

______________________________ __________________
Signature of Patient or Responsible Party Date

______________________________ __________________
Witness Date

Family Size and Income

Patient Name: ______________________________ Chart Number: __________

Instructions:

Please select your **family size** in the far left column. Then circle your **income range** to the right of your selected family size (in the same row.)

Family Size	Income Range			
1	0-10,890	10,891-16,335	16,336-21,780	Over 21,780
2	0-14,710	14,711-22,065	22,066-29,420	Over 29,420
3	0-18,530	18,531-27,795	27,796-37,060	Over 37,060
4	0-22,350	22,351-33,525	33,526-44,700	Over 44,700
5	0-26,170	26,171-39,255	39,256-52,340	Over 52,340
6	0-29,990	29,991-44,985	44,986-59,980	Over 59,980
7	0-33,810	33,811-50,715	50,716-67,620	Over 67,620
8	0-37,630	37,631-56,445	56,446-75,260	Over 75,260
9	0-41,450	41,451-62,175	62,176-82,900	Over 82,900
10	0-45,270	45,271-67,905	67,906-90,540	Over 90,540
11	0-49,090	49,091-73,635	73,636-98,180	Over 98,180
12	0-52,910	52,911-79,365	79,366-105,820	Over 105,820
13	0-56,730	56,731-85,095	85,096-113,460	Over 113,460
14	0-60,550	60,551-90,825	90,826-121,100	Over 121,100
15	0-64,370	64,371-96,555	96,556-128,740	Over 128,740