

DOUGLAS COUNTY DENTAL CLINIC
POLICY/PROCEDURE
BROKEN AND CANCELLED APPOINTMENTS
UPDATED: June 30, 2009

This document explains DCDC's "Broken and Cancelled Appointments" policy. **Please read it carefully and recognize your rights and responsibilities as our patient.**

The dental clinic will allow only **two (2) broken appointments in a 12-month period**. An appointment is considered to have been broken if any of the following occur:

1. The patient fails to show up for a scheduled appointment,
2. The patient presents more than fifteen (15) minutes late for a scheduled appointment,
or
3. The patient calls to cancel a scheduled appointment with *less than twenty-four (24) hours* advance notice.

When a patient accumulates three (3) broken appointments in a 12-month period, he/she will not be allowed to schedule any further routine appointments for a period of **six (6) months** following the third broken appointment. Emergency treatment will be allowed on a walk-in basis during the dismissal period.

Patients who continually fail appointments may be **permanently dismissed** from the clinic at the Executive Director's discretion.

I, _____, have received a copy of DCDC's
print patient's name
Broken and Cancelled Appointments policy.

Signature of Patient or Parent/Guardian

Date

Douglas County Dental Clinic/ Clínica Dental del Condado Douglas

Patient Registration/ Registro del Paciente

Date/Fecha: _____

Time/Hora: _____

Patient Name/Nombre del Paciente: _____

Birth Date/Fecha de nacimiento: _____ Sex/Genero: M F

Race/Raza: African-American Afroamericano Asian Asiatico Hispanic Hispano Multi-Racial Multiracial Native American Nativo White Blanco Other Otra

Address/Domicilio: _____

City/Ciudad: _____ County/Condado: _____ Zip Code/C.P.: _____

Home Phone/Tel. Hogar: _____ Other Phone/Tel. alternativo: _____

Email Address/Dirección de correo electrónico: _____
Your email address will only be used for confirming appointments. / Sólo se utilizará la dirección de correo electrónico para confirmar las citas.

What is your preferred method of contact? / ¿Cuál es su método preferido de contacto?: Phone Telefono Email Email Mail Correo

Social Security Number/Número de Seguro Social: _____ -- _____ -- _____

If the patient is under 18 years old, name of parent or guardian: _____
Si el paciente es menor de edad, nombre del padre o tutor:

Relationship to patient/ Parentezco con el paciente: _____

Emergency Contact/Contactos en caso de emergencia: Name/ Nombre: _____

Address/ Domicilio: _____

Relationship to patient/ Parentezco con el paciente: _____ Phone/Tel.: _____

Housing/ Vivienda: Rent Renta Own Propietario Stay with friends/family Vive con amigos/familiares Shelter Albergue Homeless Indigente

Marital Status/ Estado civil: Single/Divorced Soltero/Divorciado Married/Living Together/Common Law Casado/Mancomunado

Enrolled in college/ estudiante universitario? Yes/Sí No/No

Medical Benefits/ Beneficios Médicos? Medicaid HealthWave Indian-Health Ryan White Title II

Referral Information / Información de Remisión

Whom may we thank for referring you to our clinic? / ¿Quién podemos agradecer por referirte a nuestra clínica? Another patient, friend Otro paciente, amigo Another patient, relative Otro paciente, relativo

Dental Office Oficina Dental Yellow Pages Páginas Amarillas Newspaper Periódico School Escuela Work Trabajo Other Otro _____

Name of person or office referring you to our clinic: _____
Nombre de la persona o de la oficina que le refiere a nuestra clínica: _____

Douglas County Dental Clinic/Clínica Dental del Condado Douglas

Health History – Part II / Historial Médico 2da. Parte

Do you have a history of any of the following? (Please circle all that apply):
 ¿Tiene un historial de las siguientes condiciones? (Por favor encierre las que apliquen):

Blood or blood clotting disorders <i>Enfermedades sanguíneas o de coagulación</i>	Kidney disease <i>Enfermedades del riñón</i>	Positive HIV test / AIDS <i>SIDA/ Prueba positiva del VIH</i>
Prolonged Bleeding <i>Hemorragia prolongada</i>	Persistent cough <i>Tos persistente</i>	Seizures <i>Ataques de apoplejía</i>
Aspirin Therapy <i>Terapia de aspirina</i>	Emphysema <i>Enfisema</i>	Chemical Dependency <i>Dependencia química</i>
Anemia <i>Anemia</i>	Asthma <i>Asma</i>	Stomach/intestinal problems <i>Problemas Estomacales/intestinales</i>
Hardening of the arteries <i>Endurecimiento arterial</i>	Diabetes <i>Diabetes</i>	Fainting/Dizziness <i>Desmayos/ Mareos</i>
Chest Pain <i>Dolor de pecho</i>	Thyroid disease <i>Enfermedad de la tiroide</i>	Latex Allergy <i>Alergia al latex</i>
Swollen Ankles <i>Inflamación de los tobillos</i>	Liver disease <i>Enfermedad del hígado</i>	Steroid Medication <i>Medicamentos esteroides</i>
High blood pressure <i>Alta presión sanguínea</i>	Hepatitis <i>Hepatitis</i>	Organ Transplant <i>Transplante de órganos</i>
Heart problems <i>Problemas del corazón</i>	Urinary tract problems <i>Problemas de la vía urinaria</i>	Depression <i>Depresión</i>
Heart murmur <i>Soplo en el corazón</i>	Difficulty urinating <i>Dificultad al orinar</i>	Chronic Mental Illness <i>Trastorno mental crónico</i>
Mitral Valve Prolapse <i>Prolapso de la válvula mitral</i>	Frequent headaches <i>Dolores de cabeza frecuentes</i>	Arthritis <i>Artritis</i>
Rheumatic heart disease or fever <i>Reumatismo cardíaco o fiebre reumática</i>	Shortness of Breath <i>Falta de aire</i>	Glaucoma <i>Glaucoma</i>
Stroke <i>Apoplejía</i>	Seasonal Allergies <i>Alergias estacionales</i>	Ear, Nose or Throat Problems <i>Problemas del oído, nariz o garganta</i>
Stent <i>Stent (prótesis endovascular)</i>	Skin diseases <i>Enfermedades de la piel</i>	Osteoporosis <i>Osteoporosis</i>
Sexually transmitted disease <i>Enfermedades transmitidas sexualmente</i>	Cancer <i>Cancer</i>	Tuberculosis <i>Tuberculosis</i>
Prosthetic joints or heart valves <i>Articulaciones o válvulas prostéticas</i>	Chemotherapy or radiation therapy <i>Quimioterapia o radiación</i>	

Bisphosphonate medication (e.g. Bonifos, Reclast, Skelid, Zoledronate (Zometa), Pamidronate (Aredia), Alendronate (Fosamax), Risedronate (Actonel), Etidronate (Didronel), Ibandronate (Boniva))
 Bisfosfonatos (Bonifos, Reclast, Skelid, Zoledronate (Zometa), Pamidronate (Aredia), Alendronate (Fosamax), Risedronate (Actonel), Etidronate (Didronel), Ibandronate (Boniva))

Are you pregnant? Y N Are you nursing? Y N Are you post-menopausal? Y N Are you taking birth control pills? Y N
 ¿Está embarazada? S N ¿Está amamantando? S N ¿Le ha ocurrido la menopausia? S N ¿Toma anticonceptivos? S N

Do you have any disease, condition or problem not listed? Y N
 ¿Tiene alguna enfermedad, trastorno o problema no mencionado? S N

If yes, please explain:
 Si es así, favor de explicar:

Date/Fecha: _____
Name/Nombre: _____

Douglas County Dental Clinic/Clínica Dental del Condado Douglas

Family Income/ Ingreso Familiar

How many people live in the patients household? _____
 ¿Cuántas personas residen en el hogar del paciente? _____

Are they all dependent upon the same income? _____
 ¿Todos dependen del mismo ingreso? _____

Names and ages of all household members
 Nombres y edades de todos los miembros del hogar

Please list the net monthly income or payments from ALL sources for all persons in the patient's household.
 Favor de nombrar el ingreso neto mensual o pagos de TODAS las personas en el hogar del paciente.

<u>Income type</u>	<u>Net amount/Cantidad neta</u>
Wages (including tips)/Sueldo	_____
Odd jobs for cash/ trabajo pagado a sueldo	_____
Self Employment/ Autoempleo	_____
Support from family/friends/ Mantenimiento de familiares/amistades	_____
Unemployment Compensation/Compensación de desempleo	_____
Worker's Compensation/ Compensación por lesiones en el trabajo	_____
Cash Assistance/ Asistencia monetaria	_____
Child Support/ Mantenimiento Filial	_____
Foster Child Support/ Mantenimiento por hijos adoptivos	_____
Alimony/ Pensión alimenticia	_____
Social Security (SSI/SSDI)/ Pensión del Seguro Social	_____
Pension/Retirement Benefits/ Pensión de jubilación	_____
Veteran Benefits/ Pensión de veteranos	_____
Other income not listed/ Algún otro ingreso	_____
TOTAL NET INCOME/ INGRESO NETO	_____

If no income is reported, you must explain how the household is supported; how rent, utilities and meals are paid.
 Si no se reporta un ingreso, se debe comprobar como se mantiene el hogar o sea como se paga la renta, los servicios y la comida.

By signing below, I certify that the information provided is true and correct to the best of my knowledge. To avoid duplication of services, I will supply updated information to Douglas County Dental Clinic if my financial and/or medical benefits status changes. I also agree to apply for other forms of assistance that may be available to me. I also understand that failure to disclose these changes, falsifying information, or failure to provide proof of income may result in discontinuation of services at Douglas County Dental Clinic. I consent to the release of information on these forms to appropriate agencies and funding sources, with the understanding that appropriate confidentiality will be maintained.

Al firmar, certifico que la información proporcionada es verídica y correcta hasta donde yo sé. Para evitar la duplicación de los servicios, proporcionaré a la Clínica Dental del Condado Douglas información actualizada con respecto a cambios en mi situación económica. También accedo a solicitar otras formas de asistencia que se me ofrezcan. A la vez, entiendo que no divulgar estos cambios, falsificar información o no proporcionar prueba de mi ingreso puede resultar en la discontinuación de servicios en la Clínica Dental del Condado Douglas. Doy mi consentimiento a la publicación de los datos en estas formas a las agencias apropiadas y recursos de fondos, suponiendo que la confidencialidad adecuada se mantendrá.

SIGNATURE / FIRMA _____ Patient () Parent () Legal Guardian ()
 DATE / FECHA _____ Paciente () Padre () Tutor ()

Douglas County Dental Clinic

Treatment Policy

- I understand that I may receive services at Douglas County Dental Clinic only if I do not have dental insurance and provide proof of income to show that I qualify for services.
- I agree to pay for the services I receive according to Douglas County Dental Clinic's sliding scale.
- I understand that payment is due at time of service.
- I understand that DCDC may increase fees annually as our operating costs increase.
- I consent to dental evaluation and treatment by staff and volunteers of Douglas County Dental Clinic, including dental students and dental hygiene students.
- I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to the results of examination and treatment at Douglas County Dental Clinic.
- I understand that I must provide true and complete information when filling out forms.
- I understand the importance of my health history and affirm I have given any and all information that may impact my care. I understand that failure to give true and complete health information may adversely affect my care and lead to unwanted complications. I will inform the dentist or hygienist of any changes to my health or medications at each appointment before treatment begins.
- I understand that the Douglas County Dental Clinic is not responsible for any bills incurred outside of the services it provides for me, such as emergency room visits, medications or supplies.
- I understand that if I do not arrive within 15 minutes of the scheduled appointment time, another appointment may have to be made.
- I understand that an adult must accompany children under 18 years of age and must be present at the clinic for the duration of the appointment.
- I understand that the Douglas County Dental Clinic staff can dismiss me. Reasons for dismissal may include but are not limited to the following:
 - Two missed appointments without calling 24 hours in advance to cancel.
 - Threatening or abusive behavior while at the clinic.
 - Not following the dentist's advice that has been given to benefit my health.
 - Failure to provide true and complete information.
 - Not showing up for, or canceling without 24 hours notice, an appointment with a provider we refer you to.
- I understand that dismissal means denial of future services at the Douglas County Dental Clinic. A 6 (six) month dismissal or a permanent dismissal will be given at the Executive Director's discretion.
- I consent to sharing of my health information with other health care providers as needed to facilitate my care.
- I understand that Douglas County Dental Clinic staff are required by law to report any suspicion of child or adult abuse, including neglect or emotional, physical or sexual abuse.
- I consent to have blood tests in the event of exposure of a Douglas County Dental Clinic staff member to my blood or bodily fluids. Douglas County Dental Clinic agrees to pay for the testing it requests. Testing will be performed by the provider of Douglas County Dental Clinic's choice.
- I authorize Douglas County Dental Clinic to take permanent possession of any extracted teeth and/or tissues and retain or dispose of these specimens in any manner whatsoever.
- I have read the statements above, and I understand them or someone has clarified to me anything I did not understand. I agree to the terms stated here and I willingly provide information about myself in order to receive care.

SIGNATURE _____
PATIENT OR GUARDIAN

DATE _____

Douglas County Dental Clinic/ Clínica Dental del Condado Douglas

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSTANCIA DE RECIBO DE AVISO DE PRACTICAS DE PRIVACIDAD

****You May Refuse to Sign This Acknowledgement****

****Tiene el derecho de negarse a firmar esta constancia****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Yo, _____, he recibido una copia del aviso de practicas de privacidad.

{Print Name/nombre en letra de molde}

{Signature/Firma}

{Date/Fecha}

For Office Use Only/Solamente para uso oficial

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)