Consent to Hygiene Care:

Patient First Name ____________________________________
Patient Last Name ____________________________________
Patient Birthdate ____________________________________

BACKGROUND
The 2017 Wisconsin Act 20 Practice of Dental Hygienists specifies that, in settings other than a dental office, the authorization and presence of a licensed dentist are not required for the practice of dental hygiene. Under prior law, the permission and presence of a licensed dentist were necessary in most cases. Please visit our website at www.rdhcommunications.org for more information.

DIRECT ACCESS
You need to understand the scope of what a dental hygienist can and cannot do. A hygienist can see patients to provide oral hygiene advice and remove stains, tartar, bacterial deposits, and other debris. In relation to gums, the hygienist can advise you on the progression of gum disease, but more advanced conditions need to be assessed by a dentist, and the hygienist then continues treatment under the prescription of the dentist. Dental hygienists cannot diagnose or give the prognosis (the likely outcome) of diseases such as decaying and broken teeth, or prescribe antibiotics, painkillers, or any other drugs to alleviate symptoms.

Reminder:
Visits from our direct-access dental hygienists are not a substitute for routine dental checkups with a licensed dentist.

REFERRAL TO A DENTIST
If the hygienist advises you to see a dentist, it is because they feel that it is in the interests of your health, it is outside the scope of what they are legally allowed to do, or they are uncertain about treating you without further advice.

There are very rare circumstances when a hygienist cannot start treatment, and before they are prepared to continue, insist that a dentist assesses you. These may relate to your medical history and general health, or the condition of your mouth, which gives them concern.

CONSENT
I, ____________________________________ (patient name and/or legal guardian) have read and understand the limitations of direct access to a dental hygienist and agree to be treated under the direct access arrangements. I understand that the hygienist is not responsible for the overall health of my mouth and that regular visits to a dentist are still required.

Legal Guardian Signature and/or patient signature

____

Date ____

Financial Agreement

Do you have Forward Health Insurance? YES NO
Can we submit to Forward Health? YES NO
If yes, member number ______________________________
*No other insurance we accept, only Forward Health.

Are you paying out of pocket? YES NO

*All payments are processed through Quickbooks.
**Checks accepted and a quote will be given.

Legal Guardian Signature and/or patient signature

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Date ____

HIPAA Disclosure Form:

CONSENT FOR DISCLOSURE OF HEALTH INFORMATION-HIPAA

SECTION A: PATIENT GIVING CONSENT
Patient First Name

____

Patient Middle Name

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Patient Last Name

____

If someone other than the patient completing this form please list name and title here:

____

SECTION B: TO THE PATIENT: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Privacy Practices: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed on this form. Please understand that revocation of this consent will not affect any

action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

WISCONSIN ADDENDUM TO NOTICE OF PRIVACY PRACTICES

This Addendum to the Notice of Privacy Practices sets forth Wisconsin Privacy Requirements that are in addition to this is our Notice of Privacy Practices (Federal HIPAA Law). Please review carefully. The Privacy of Your Health Information is Important to Us.

We are required by Wisconsin law to maintain the privacy of your health information.

Uses and Disclosures of Health Information

Healthcare Operations:
Under Wisconsin law, we must have your written permission before we may use and disclose your health information in connection with healthcare operations other than the management of our medical records and certain auditing and review activities by staff committees and review organizations.

To Persons Involved in Your Care:
Under Wisconsin law, we must have your written permission before we may use and disclose your health information, other than limited identifying information to persons involved in your care.

Abuse or Neglect:
Under Wisconsin law, we must have your written permission before we may use and disclose your health information to the appropriate authorities if we believe you are the victim of domestic violence or other crimes. We may report abuse or neglect of a child or vulnerable adult as allowed by Wisconsin law.

Patient Rights
Restrictions: While we are allowed to determine whether we agree to your request to restrict our use and disclosure of your protected health information, Wisconsin law requires we honor certain restriction requests by private pay patients relating to research or the release of information to government agencies.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Contact officer:
Jenny Maxwell
info@rdhcommunications.org
#262-510-9104

SECTION C: THE USES AND DISCLOSURES BEING AUTHORIZED
Our Use of Dental Health Information:
By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and

healthcare operations as set forth in our Privacy Practice Notice.

Persons Involved in Care:
By signing this form, you will consent to our use and disclosure of your dental care records to the following persons, including those involved in the payment of your care. We may also use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing those involved in your care or payment for that care.

Please list the person(s) you would like involved in your care:

____

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Privacy Practice Policy: A copy will be emailed to the patient / legal guardian

SIGNATURE FOR CONSENT
I, the patient/and or legal guardian have had the full opportunity to read and consider the content of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Legal Guardian Signature and/or patient signature

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Date ____

Medical Consent Form

First Name ______________________________________
Middle Name ______________________________________
Last Name ______________________________________
Date of birth ____________________ Gender ___________
Email address ______________________________________

Preferred contract method: Email Phone call Text
Phone # ____

Mailing address:

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Emergency Contact: _________________________________
Relationship to: ____________________________________
Phone # ____

Social Security # ___________________________________

Dental Information

Previous or current dental provider? ____________________

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Are you currently in pain or discomfort? YES NO
Do you wear dentures or partials? YES NO
Have you had previous problems with dental treatment?
YES NO

Have you had any periodontal (gum) treatment? YES NO

Have you ever had a serious injury to your head, neck, or mouth? YES NO

Medical Information

Current family doctor? ______________________

If so, which location? ______________________

Date of last physical examination? ______________________

Have you had a serious illness, operation or been hospitalized in the past 5 years? YES NO

If yes, what was the illness or problem?

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Have you had a joint replacement? YES NO

If yes, date, location of joint? ______________________

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Do you take a dental premedication? YES NO

Current cough or flu-like symptoms? YES NO

Have you ever taken FosaMax, Boniva, Actonel, or other medications containing bisphosphonates? YES NO

Please list current over the counter medications and prescription medications.

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Any allergies to medications? Materials? seasonal allergies?

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Please circle all that apply:

Abnormal bleeding	AIDS/HIV	Alzheimer’s/Dementia
Anemia	Angina	Anxiety
Arthritis	Asthma	Autoimmune disease
Back problems	Blood disease	Blood transfusion
Breathing problems/respiratory disease		
Cancer/chemotherapy/radiation treatment		Chronic pain
Diabetes	Eating disorder	Epilepsy
Fainting/dizziness	Digestive disorder	Glaucoma
Hearing difficulties	Heart disease	Hepatitis
Liver disease	High blood pressure-	Or low BP

Low pain tolerance	Malnutrition	Nerve disorder
Night sweats	Bone disease	Pacemaker
Psychiatric care	Severe migraines/headaches	
Weight loss/weight gain		Sinus trouble
Stroke	Sexual transmitted disease	
Thyroid problems	TMJ	Tuberculosis
Tumors or growths	Ulcers	Other

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Legal Guardian Signature and/or patient signature

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Date ____

PHOTO/VIDEO CONSENT AND RELEASE FORM

The undersigned hereby grants permission to RDH Communications LLC ("RDH") and its officers, members, agents, and employees the right to reproduce photographs and/or video images and recordings taken of the undersigned for the purposes of publication, promotion, illustration, advertising, marketing, or trade, in any manner or in any medium, including on printed materials, as well as RDH online presences. The undersigned hereby agrees to release and hold harmless RDH and its officers, members, agents, and employees from any claims or liability associated with the use of such images as described above, and waive any right to compensation for the use of such images.

___ Check here if you ACCEPT photo/video consent.

___ Check here if you DECLINE photo/video consent.

____

Signature (of Individual or Legal Representative)

____

Relationship of Legal Representative to Individual

____

Date