ALAMO COLLEGES DISTRICT
Palo Alto College
Dental Hygiene

Palo Alto College

Dental Hygiene Program - Standards of Patient Care

These standards of patient care have been developed by the Palo Alto College Dental Hygiene Program and Clinic to describe clinical considerations in the diagnosis and treatment of oral health conditions and, accordingly, to serve as a basis for clinical decision-making. Additionally, these standards will assist students, faculty and staff in executing the school's commitment to delivering high-quality, care that is patient-centered, demonstrable and continuously improving.

1. The patient will be treated in a professional manner at all times.
2. The patient's chief complaint, concerns and expectations will be addressed by treatment in the dental hygiene clinic or an outside referral.
3. The patient's dental and medical histories will be considered in the identification of predisposing conditions and medications that may affect the prognosis, progression and treatment of their current oral disease status.
4. The patient will receive a clinical and appropriate physical evaluation with vital signs noted, as indicated by the patient's history and presentation, to include evaluation of extra-oral and intra-oral tissues and structures, yielding a risk assessment status.
5. The patient will receive an adjunctive diagnostic evaluation, such as various radiographs and possibly intraoral images as indicated and needed from the clinical and physical evaluation and presentation of findings.
6. When radiographs are obtained, they will be based on the diagnostic needs of the patient and of diagnostic quality. An interpretation of radiographs will be included in the patient's record.
7. When dental care is required that exceeds the scope of practice for the dental hygiene program, or the scope of a dental hygienist, or at a patient's written request, the patient will be referred to the appropriate dental and/or healthcare professional(s) for care.
8. The determination of a dental hygiene treatment need, based upon all assessment data, will be utilized when evaluating oral conditions of the patient and in the development of a dental hygiene care plan.
9. The behavioral, psychological, anatomical, developmental and physiological limitations of the patient will be considered when developing a care plan.
10. The patient will be advised of the dental hygiene treatment need, the recommended care needed based upon the treatment need, care options (if any), and the benefits, prognosis, limitations and risks associated with those treatment recommendations, as well as, the probable consequences of no care.
11. The patient will receive the appropriate information regarding the prevention and early detection of oral diseases through patient education in preventive oral health practices, including oral hygiene instructions.
12. Any treatment performed will be with the written consent and approval of the dental hygiene faculty and the written consent of the patient. If the patient insists upon treatment that is not considered by the dental hygiene faculty to be beneficial, the dental hygiene faculty will consult with the supervising dentist to determine the level of treatment considerations. The school may decline to provide treatment.
13. Medications will be prescribed by the attending dentist.
14. The patient's medical history, vital signs, treatment need and care plan will be reviewed and updated as indicated, at each treatment appointment.
15. Documentation of all examinations, dental hygiene treatment need, risk assessment factors, care provided, counseling, recommended preventive measures and consultations with and referrals to other health care professionals will be included in the patient's dental record.
16. The dental hygiene students, faculty and staff will treat all communications and records pertaining to a patient's care as confidential. No patient information will be released for any reason without the written consent of the patient; this includes information for educational purposes.

These standards are to assist in the quality assurance activities of the Palo Alto College Dental Hygiene Program and for your protection.

I certify that I have read this document or have had the document explained to me so that I understand its content.

Signature of Patient: _____ ***Date:*** _____

I am the parent or legal guardian of _____ and have read or have had this document explained to me (if the patient is younger than eighteen (18) years of age).

Signature of Parent or Legal Guardian (for a minor child) _____ Date: _____

ALAMO COLLEGES DISTRICT
Palo Alto College
Dental Hygiene

NOTICE OF PRIVACY PRACTICES

Palo Alto College Dental Hygiene Program
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210-486-3315

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.
HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. The Patient will sign and receive a copy of this document **one time per year**. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, or health care operations. Examples of how we use or disclose information for treatment purposes are:

- setting up an appointment for you;
- examining your teeth;
- prescribing medications
- faxing the prescribed medication to be filled;
- referring you to another doctor or clinic for other health care or services;
- getting copies of your health information from another professional that you may have seen before us.

We do not file insurance claims. "Health care operations" means those administrative and managerial functions that we have to do in order to run our dental hygiene program and clinic.
Examples of how we use or disclose your health information for health care operations are:

- financial audits;
- internal quality assurance;
- defense of legal matters;
- business planning;
- storage of our records.

We routinely use your health information inside our dental hygiene program and clinic for these purposes without any special permission. If we need to disclose your health information outside of our dental hygiene clinic for these reasons, **we will ask you for special written permission before using**.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our dental hygiene clinic at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

- uses or disclosures for health-related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS
We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. A Student will call to schedule and remind you of your appointments. Unless you tell us otherwise, we will leave you a reminder message on your voicemail or with someone who answers your phone. (Please note, your appointment is not considered confirmed, unless there is a verbal confirmation of receiving the message.)

OTHER USES AND DISCLOSURES
We will not make any other uses or disclosures of your health information **unless** you sign a written "authorization form." The content of an "authorization form" is determined by federal law. **The dental hygiene program will only use your information after receiving your written authorization.**

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, a written request must be sent to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30-days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60-days from when you ask us. We will send the corrected information to persons who we know received the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a

written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone to the person shown at the beginning of this Notice.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

By Signing this document below, I am attesting that I have read the document, I understand the document, I acknowledge the content of this document, and I accept the contents of this document:

Patient Name:_____ Signature: _____ Date: _____

---------- tear here ----------

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Palo Alto College Dental Hygiene Program Notice of Privacy Practices.

Patient name:

Signature _____ Date: _____

Reviewed by:
Office of General Council

ALAMO COLLEGES DISTRICT
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EXHIBIT 6-1.6 CONSENT AND AGREEMENT FOR TREATMENT

Please read the following information carefully. After you have read this Consent and Agreement, please sign your name below to agree to the terms of this agreement.

1. **Consent to Treat:** As a consenting adult, I agree that students or faculty at Palo Alto College Dental Hygiene Program to provide dental care to myself, my child, or patient representative as applicable.

2. **Teaching facility:** As a patient at Palo Alto Dental Hygiene, all dental treatment will be provided by faculty or students under the supervision of clinical faculty.

3. **Limitations**: Not all persons can be accepted as a Palo Alto Dental Hygiene. Persons with complicated medical conditions, rigid time requirements, and extremely difficult dental care needs may not be accepted. I understand that if I am accepted as a patient, treatment at Palo Alto College Dental Hygiene may be limited, after which time I would need to find dental care within the public sector.

4. **Emergency:** Emergency treatment for relief of severe discomfort is not available at Palo Alto College Dental Hygiene

5. **Treatment Plan:** Care and treatment at school takes longer than in private dental practice. Appointments may be up to four hours long , and I, the patient and/or patient representative must be prepared for multiple visits to complete my dental care needs.

6. **Right to Discontinue Treatment:** Palo Alto College Dental Hygiene has the right to discontinue treatment for any appropriate reason, such as excessive cancellations. In such cases, the patient or the patient's representative agrees to accept full responsibility for seeking alternative professional dental care. A letter will be sent informing the patient or the patient's representative that treatment will be discontinued. All records related to the treatment and diagnosis of patients are the property of the Palo Alto College Dental Hygiene program. Records and x-rays will be duplicated upon written request at a reasonable charge to the patient.

7. **Payment for Services:** I am expected to pay for the treatment I receive. Palo Alto Dental Hygiene has the right to revise fees at any time, for any procedure that has not yet been started. During the course of my dental care, unexpected complications or new conditions may arise that may result in additional costs. If my treatment becomes too complex for a dental hygiene student to manage, it may be necessary for me to be referred to a primary care dentist.

8. **Risk of treatment:** The faculty at Palo Alto Dental Hygiene are available to answer any questions concerning the risk involved with specific procedures. All dental procedures have certain risks, including possible side effects of some medications used in dentistry. These risks include, but are not limited to:

a) allergic reaction b) Cuts/abrasions c) tenderness/bruising from injections d) Sensitive teeth

9. **Follow-Up Appointment:** I understand that by accepting treatment at Palo Alto College Dental Hygiene I also consent to future follow-up appointments for the purpose of assessing the outcome of the treatment provided to the patient.

10.Accept Photography: I understand that photographs, videos, digital images, and other images may be recorded to document and assist with my care. These images may be used to assist in the education of the student and resident within the institution. I understand that Palo Alto Dental Hygiene will own these images, but that I will be allowed access to view them or to obtain copies of them at a reasonable cost. Other than for treatment and education purposes, images that identify me will be release and/or used outside of the organization only upon written authorization from me or the patient's representative.

Practice Privacy Notice: Palo Alto College Dental Hygiene may release information to other entities or health care providers, for treatment, payment of services, and for health care operations as described in the "Notice of Privacy Practice." Palo Alto Dental Hygiene has prepared this detailed document to help you better understand our policies and regard to the use and disclosure of personal health information.

I have been given the opportunity to review and receive a copy of the Notice of Privacy Practices.

Please initial: _____

a) Consent to treatment : By signing below, I am indicating that I have read and I understand the terms of the Consent and Agreement for Treatment. I am either the patient or have the authority to give consent for the patient. I give consent to Palo Alto Dental Hygiene to perform the necessary or appropriate tasks for proper dental and physical examination, diagnosis, and treatment, including local anesthesia.

My questions about this consent and agreement have been answered.

_____ _____

Signature of Patient or Representative **Date**

ALAMO COLLEGES DISTRICT
Palo Alto College
Dental Hygiene

Patient Bill of Rights

As a patient in the Palo Alto College Dental Hygiene Program, you, the patient has the right to:

1. Considerate, Respectful and Confidential Treatment.
2. Be treated to the standard of care for all dental hygiene treatment needs.
3. Continuation and completion of dental hygiene treatment that is initiated in our program as outlined in the dental hygiene care plan provided to the patient.
    a. The completion of care includes the patient's obligation to arrive to and keep all scheduled appointments to prevent a void in the student's learning.
    b. The completion of care also includes patients keeping their appointments as scheduled with the student.
    c. **Please Note**:
        i. ***Patient cancellations cannot exceed two times, without a 24-hour notice, otherwise treatment will be discontinued in the dental hygiene clinic. Please keep in mind, cancellation affect the students' learning abilities.***
        ii. ***Late arrivals to appointments are limited one time not to exceed 15 minutes. This too, affects the students comprehensive learning.***
4. Access to complete and current information that pertains to dental care and to have the information explained to me in understandable terms, except where restricted by law.
5. Explanation of all recommended treatment modalities, including the option to refuse treatment.
6. Explanation of all risks that are involved with treatment and the expected outcomes, if I comply with the treatment recommendations.
7. Be informed of the complete dental hygiene treatment need and treatment care outlined reflecting the cost of the care in the private sector.
8. An explanation of the costs that will be incurred in our facility based upon the age of the patient.

This Patient Bill of Rights is to assist in the quality assurance that is a significant policy of the Palo Alto College Dental Hygiene Program. It is stated to insure that the patient is aware of their rights when receiving treatment in our Clinic.

By signing this document, I am stating that I have read, I understand, and I accept these rights stated above.

Printed Name: _____ Signature: _____ Date: _____

I am the legal guardian of the patient_____
I have read, I understand, and I accept these rights stated above for the patient.

Printed Name: _____ Relationship: _____

Signature of Guardian Patient: _____ Date: _____