Delhi Community Health Center
Delhi, LA

Delhi Community Health Center
Dental Clinic

605 Broadway Street, Delhi, Louisiana 71232 \ (318) 878-6350

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

CONSENT FOR TREATMENT: I authorize Delhi Community Health Center Dental Clinic (DCHC-DC) and such assistants as they may designate, to carry out dental treatment for myself or minor child including but not limited to: examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. I understand that my condition may call for a consultation with another Dental Provider. If this situation occurs, I authorize DCHC-DC to release any dental information that may be needed to better provide for my medical treatment.

NOTICE OF PRIVACY PRACTICES: Our Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition related health care services.

Medicare: Please provide a copy of your Medicare card and any supplemental insurance card at each visit. If you have a share of the cost for your visit, you will be asked to pay that amount at the time of service. **By providing household income and family size, you may qualify for DCHC Sliding Fee Discount Program.**

Medicaid: Please provide a copy of your current Medicaid card at each visit. Medicaid covers all services provided at DCHC-DC. You will have no cost sharing if you receive covered services under your Louisiana Medicaid or Medicaid Managed Care Plan ***unless you have exhausted your plan's dental benefits***. You can then be assessed for a sliding fee discount. *If you are covered under the "Take Charge" program, you only qualify for family planning services and defined conditions; you are responsible for payment of all other services.

Private Insurance: Please provide a copy of your current insurance card at each visit. Some insurance plans pay a percentage of charges. You are responsible for paying the remaining charges. Other insurance companies require a co-payment at each visit (stated on back of insurance card). You are responsible for pre-paying the co-pay amount prior to each visit.

Self-pay/no insurance: DCHC-DC has programs that can help you pay for your healthcare. You may apply for insurance enrollment assistance through our Enrollment Assistance Program- located at the 109 Elm Street location. You may also apply for DCHC-DC Sliding Fee Discount Program which takes into consideration your annual household income and family size. You must apply for these programs and submit any required documents.

Types of Payments: DCHC-DC accepts check payments. If a check payment is returned for insufficient funds, we will attempt a second time to obtain payment through your banking institution. Following a second attempt without payment, we will try to contact you by phone to resolve the matter. If an acceptable resolution cannot be reached following our discussion, or we are unable to contact you, we must turn the matter over to the authorities. After this point, check payments will not be accepted. We also accept credit card payments. We can discuss maintaining your credit card information on file at DCHC-DC if you are interested in this option. When your payment is in cash, you will be provided with a

Delhi, LA

Delhi Community Health Center
Dental Clinic

605 Broadway Street, Delhi, Louisiana 71232 \ (318) 878-6350

receipt so that you will have a record of your payment. Please make us aware if you are not provided a receipt for a cash or credit card payment.

Filing Insurance: DCHC-DC will file your medical insurance as a courtesy to you. However, it is important to remember that your insurance is a contract between you and your insurer. You are responsible for payment of services regardless of the amount your insurance pays.

By signing below you give your consent for treatment at DCHC-DC, acknowledge receipt of our HIPAA privacy practices, and agree to our financial policy.

X_____ X_____ X_____

Print Name of Patient | Signature of Patient or Responsible Party | Date

Thank you for choosing DCHC-DC as your dental care provider. Please let us know if you have questions or concerns.

You will receive a separate billing statement from Delhi Hospital or other source if additional tests were done outside DCHC-DC. If you qualify for the Sliding Fee Discount Program at DCHC, the discounts will also apply at Delhi Hospital and Delhi Rural Health Clinic. You will be notified prior to any service if there are subsequent charges over and above the usual and customary fees associated with a typical visit. (i.e. supplies or equipment) All Delhi Community Health Center locations and our website have instructions on how to contact us after hours and what to do in case of emergencies.

For after-hours contact call 318.878.6650.
For after-hours emergencies dial 911 or go to the nearest emergency room.

MEDICAL HISTORY – DENTAL CLINIC *Medical History will be updated every (6) months, otherwise services cannot be rendered

Name _____

Primary Care Physician: _____ Phone: _____ Date of last exam: _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any Surgical operations or serious illness?	☐	☐
3. Are you under a Narcotics Pain Contract?	☐	☐
4. Have you ever been pre-medicated with Antibiotics for your dental treatment?	☐	☐
5. Are you taking any medication (s) Including non-prescription medicine and injections? If YES what medications are you taking? _____ _____	☐	☐
6. Do you use tobacco?	☐	☐
7. Do you use alcohol, cocaine, other drugs?	☐	☐
8. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following? e.g (please check yes or no)	YES	NO
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other _____		
9. Women only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

Do you have or have you had any of the following?

	YES	NO
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting/Seizures	☐	☐
Asthma	☐	☐
Low Blood Sugar	☐	☐
STD	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidneys	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Heart Disease	☐	☐

	YES	NO
Cardiac Disease	☐	☐
Heart Murmur	☐	☐
Hay Fever/Allergies	☐	☐
Frequently Tired	☐	☐
Recent Weight Loss	☐	☐
Emphysema	☐	☐
Radiation Therapy	☐	☐
Arthritis	☐	☐
Joint Replacement	☐	☐
Joint Implant	☐	☐
Hepatitis/Jaundice	☐	☐
Epilepsy/Convulsions	☐	☐
Stomach Trouble	☐	☐
Respiratory Problems	☐	☐

	YES	NO
Ulcers	☐	☐
Chest Pains	☐	☐
Easily winded	☐	☐
Stroke	☐	☐
Angina	☐	☐
Tuberculosis	☐	☐
Cancer	☐	☐
Glaucoma	☐	☐
Anemia	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Other _____		

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Difficulty in chewing?	☐	☐
3. Are your teeth sensitive to hot or cold Liquids and/or foods?	☐	☐
4. Are your teeth sensitive to sweet or sour liquids And/or foods?	☐	☐
5. Do you feel any pain in your teeth?	☐	☐
6. Do you have any head neck or jaw injures?	☐	☐
7. Have you experienced any of the following Problems in your jaw:		
a) Clicking?	☐	☐
b) Pain (joint, ear side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
8.		

	YES	NO
9. Do you have frequent headaches?	☐	☐
10. Do you clench or grind your teeth?	☐	☐
11. Do you bite your lips or cheeks frequently?	☐	☐
12. Have you ever had any difficult extractions in the past?	☐	☐
13. Have you had any orthodontic work?	☐	☐
14. Have you ever had any prolonged bleeding following extractions of your teeth?	☐	☐
15. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
16. Have you ever had instruction on the care of your gums?	☐	☐
17. Date of last dental check-up: _____		

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to child's health. I authorize the dentist to release any information including the diagnostic and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

Signature of Patient: _____ Date: _____

DELHI COMMUNITY HEALTH CENTER
PATIENT INFORMATION

Date: ____/_____/_____ Pharmacy _____

Doctor or (Referring Dr.) _____

Last Name _____ First Name _____ MI _____ Jr. Sr. III

Mailing Address _____
Address City State Zip

Physical Address _____

Date of Birth _____ SSN _____ - _____ - _____ E-Mail _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Consent to receive Calls ☐ Yes ☐ N **Consent to receive Text** ☐ Yes ☐ No

---

*** Children under 18 years of age must be accompanied by an adult***

Guardian: Last Name _____ First Name _____

Address _____ City _____ Zip Code _____

Date of Birth _____ SSN _____ - _____ - _____ E-Mail _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

School _____ Grade _____

Insurance Information

Company Name: _____

Policy or Card #: _____

Policy Holder's Last Name: _____ First Name: _____

Policy Holder's Date of Birth: ____/____/____ Policy Holder's SSN#: _____ - _____ - _____

Policy Holder's Address: _____ City: _____ Zip Code: _____

If Medicaid, PCP (Referring Dr.) _____

Company Name: _____

Policy or Card #: _____

Policy Holder's Last Name: _____ First Name: _____

Policy Holder's Date of Birth: ____/____/____ Policy Holder's SSN#: _____ - _____ - _____

Policy Holder's Address: _____ City: _____ Zip Code: _____

If Medicaid, PCP (Referring Dr.) _____

Delhi Community Health Center is a Federally Qualified Health Center and is required to collect population data.

Are you a veteran of the military? *(Check one)* ☐ Yes ☐ No

Gender Identity (*Check one*) ☐ Male ☐ Female ☐ Transgender Male/Male to Female

☐ Gender queer ☐ Transgender Female/Female to Male ☐ Choose Not to Disclose ☐ Other

Sexual Orientation (*Check one*) ☐ Lesbian, Gay or Homosexual ☐ Straight or Heterosexual
☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose Not Disclose

Race *(Check one)* ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander
☐ Other

Ethnicity (*Check one*) ☐ Hispanic ☐ Non-Hispanic

What is your marital status? *(Check one)* ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

Housing Status (*Check one*) ☐ Homeless ☐ Doubled Up ☐ Street ☐ Transitional ☐ N/A

Where do you usually receive your health care? *(Check one)*

☐ Emergency Room ☐ Clinic or Hospital ☐ Private Doctor

☐ Haven't received healthcare in _____ years

Who can we contact in case of emergency?

Last Name _____ First Name _____

Address _____ Phone Number _____ Relationship to you _____

How many people live in your household? _____ **Are you currently employed?** *(Check one)*

☐ Yes ☐ No

Place of employment: _____ **Phone Number:** _____

Are you an Agricultural Worker? *(Check one)* ☐ Yes ☐ No

What is your gross annual income? _____ *(Attach copies of latest check stubs)*

DELHI COMMUNITY HEALTH CLINIC

Baseline Information

Are you receiving any one of the following benefits? (We must have copies of any that are marked yes. Without proof of income, you will not receive a discounted price.)

	YES	NO	If so, how much?
Medical Assistance	☐	☐	_____
State Public Assistance	☐	☐	_____
SSI / SSDI	☐	☐	_____
Social Security	☐	☐	_____
Veterans Retirement/Disability	☐	☐	_____
Workers Compensation	☐	☐	_____
Unemployment	☐	☐	_____

Annual Income in your household

- ☐ $10,000 - 20,000
- ☐ $21,000 - 35,000
- ☐ $36,000 - 40,000
- ☐ $41,000 - 50,000
- ☐ $51,000 +

_____ _____

PATIENT'S OR GUARDIAN SIGNATURE DATE

***The following must be completed on all patients under the age of 18:**

- Are parents: Married/Civil Union_____; Separated_____; Divorced_____; Living Together_____
- If parents are no longer together, are either of the child's parents remarried: Yes No
- (list any step-parents names)_____
- Does the child live with his/her mother: Yes No If yes, does the child live with her: Full Time Part-Time
- Does the child live with his/her father: Yes No If yes, does the child live with him: Full Time Part-Time
- If the minor child's parents are divorced and/or a custody agreement is in place, please state which parent/legal guardian has domiciliary decision-making authority and custody of the minor child:_____
- If the minor child's parents or legal guardians are not married or are legally separated, please provide the court custody order or custody agreement that states who has decision-making authority and custody of the minor child.

Patient Signature: _____

Guardian Signature if patient under 18: _____

Date:_____Time: _____

DELHI COMMUNITY HEALTH CENTER-DENTAL CLINIC

605 Broadway Street
Delhi, LA 71232
Phone: 318-878-6350 Fax 318-878-8392

PATIENT INFORMATION AUTHORIZATION FORM

To Release Information from: Delhi Community Health Center-Dental Clinic
605 Broadway St
Delhi, LA 71232

Phone: 318-878-6350 Fax: 318-878-8392

I hereby authorize Delhi Community Health Center to disclose or obtain from the following requested health information from the periods of health care from:

INFORMATION TO BE DISCLOSED/OBTAINED:

- ☑ Complete Health Records
- ☐ History / Physical
- ☐ Operative Report
- ☐ Lab Reports
- ☑ X-Ray Reports
- ☐ EKG/EEG
- ☐ Consultation Report
- ☑ Progress Notes
- ☐ Discharge Summary
- ☐ Other:

Authorization expiration date or event expiration:

I understand the following information will be released when included in the above unless I indicate otherwise:

- ☐ Do not release any AIDS or HIV test results
- ☐ Do not release any records of behavioral health services/psychiatric care
- ☐ Do not release any records of treatment for alcohol and/or drug abuse

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Delhi Community Health Center-Dental Clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
I understand, unless otherwise revoked, this authorization will be in effect for the dates indicated above, or will automatically expire twelve (12) months from the date of the authorization.
I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws.
I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.
I understand Delhi Community Health Center-Dental Clinic, its affiliated entities, its employees, officers, and physicians are hereby released from my legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient Name:

Date of Birth: Last 4 Digits of SSN:

Date:

Signature of Patient or Patient Representative

Child's Name_____ Date_____

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

X_____
(signature of parent or legal guardian)

This consent shall be considered in effect until rescinded or revoked.

Patient Information about Sliding Scale

What is sliding scale?

A sliding scale is the method we use to offer discounts on healthcare from Hospital Service District No 1-A Parish of Richland State of LA d/b/a Delhi Community Health Center Dental Clinic. It is based on a patient's household size and income, and federal guidelines.

What happens if I don't apply?

You will be asked to pay the full charges for the services provided if you choose not to apply.

How can I prove my income?

- Payroll check that shows your year-to-date income
- Two most recent pay stubs
- Current wage statements (written from employer)
- One month of current unemployment check stubs
- Current bank statement that shows flow of money in/out of account
- Current statement from Social Security office
- Letter from the individual who supports the patient financially. The letter must state a specific dollar amount.
- First page of current or previous year income tax forms
- Previous year W-2 form
- For business owners, detail of the most recent 3 months of income and expenses for the business.

What if I don't bring proof of income?

You will receive a bill for the full cost of your visit/services from Delhi Community Health Center Dental Clinic.

What if this information changes?

If your income or household size changes, please inform the receptionist. You will be asked to fill out a new application and show proof of the new income.

What services does Sliding Scale cover?

Sliding scale offers discounts on the clinic visits and all services provided at Delhi Community Health Center Dental Clinic.

What services are NOT COVERED under Sliding Scale?

Sliding Scale does not cover the cost of pathology and the reading of the radiology tests done by the radiologist. You will still receive a bill from the pathologist or radiologist if those services were done. Also, Sliding Scale does not cover professional services provided by referral physicians that are not primary care physicians at one of our facilities.

What if my fees are still too expensive?

One of our clinic staff will direct you to the appropriate Certified Applications Counselors at our facility to see if you qualify for reduced cost healthcare with Medicaid or the Insurance Marketplace.

CLINIC STAFF ONLY
Scan Date: _____ Initials:

Hospital Service District No 1-A Parish of Richland
State of Louisiana
d/b/a
Delhi Community Health Center Dental Clinic

DCHC-Dental Clinic Sliding Scale Discount Application

Sliding Scale is a discount program we offer to our uninsured patients. The discount you qualify for is based on your household size and income. Please fill out this application and **provide proof of monthly gross income for ALL members of the household** to the receptionist. If you have questions, see the information on the next page or ask the receptionist for help.

(1) Household Members & Income

Applicant name: _____ **Birth Date:** _____

Please list all members of household, starting with self, including birth dates, relationship and monthly gross income. Include income that is earned (paychecks, profits, interest, savings) as well as income that is not earned (welfare, unemployment, child support, gifts, grants).

	Name	Birth Date	Relationship	Monthly Gross Income
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Total monthly gross household income (earned and unearned): $_____

(2) Acknowledgement

"This information is true and correct to the best of my knowledge. I understand that if my household's monthly gross income changes, I must fill out a new application and show proof of the new income amount. I give DCHC-DC permission to verify information about my financial status. Failure to meet those conditions may disqualify me from the future Sliding Scale fee discounts. I acknowledge that I have read the Information section on page 2 and understand what charges are covered under the sliding scale discount program. I understand that by applying for and receiving a discount does not mean that my Medical services are free and that I am responsible for remaining balances."

X Name: _____ X Signature: _____ Date: _____

☐ Patient declined to complete _____

Verified by: _____ Date: _____ Category: ☐A ☐B ☐C ☐D ☐E ☐F