

# UMMC School of Dentistry

## Dental Mission Week 2020

### February 3rd – 7th

Dear Applicant,

Thank you for your interest in our Dental Mission Week event. To apply for the free dental services that will be offered, please fully complete the attached forms and **return them to this location** before or no later than **November 22, 2019** or mail completed application to:

School of Dentistry  
Attn: Dental Mission Week  
2500 North State Street  
Jackson, MS 39216

If you are selected, you will be contacted and given a day and time to come to the UMMC School of Dentistry to be screened for treatment. If you do not receive a call by **December 31, 2019**, you were not selected. For your convenience, on your application please provide a working phone number by which you may be contacted.

**Note:**

This event is for individuals who are uninsured and have limited to no access to dental care. If you DO NOT have an appointment time, you will not be seen. Please do not come to the School of Dentistry if you are not contacted with an appointment time. We will not be able to treat unscheduled walk-in patients.

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For more information:

Call (601) 496-3232

<https://www.facebook.com/School-of-Dentistry-at-UMMC>

[https://twitter.com/UMMC\\_Dentistry](https://twitter.com/UMMC_Dentistry)

**Dental Mission Week**  
**February 3-7, 2020**



Are you a Veteran?  Yes  No

Patient Information: **Please Print & Sign**  
 Date: \_\_\_\_\_  
 Phone No. \_\_\_\_\_  
 Alternate Phone No. \_\_\_\_\_

**LAST** Name (Apellidos): \_\_\_\_\_ **FIRST** Name (Nombre): \_\_\_\_\_  
 Date of Birth (Nacimiento): \_\_\_\_\_ Age (Edad): \_\_\_\_\_ Gender (Genero):  F  M  
 Address (Direccion): \_\_\_\_\_ County (Condado): \_\_\_\_\_  
 City (Ciudad): \_\_\_\_\_ State (Estado): \_\_\_\_\_ Zip (Codigo Postal): \_\_\_\_\_

**Chief Dental Needs:** \_\_\_\_\_

<u>Health History</u> (Check all that apply)	<u>Drug/Food Allergies</u>	<u>Current Medications</u>
<u>Cardiovascular</u>	___ Latex Allergy	_____ _____ _____
___ Heart Disease	___ Penicillin	_____ _____ _____
___ High/Low Blood Pressure	___ Sulfa	_____ _____ _____
___ Mitral Valve Prolapse	___ Other _____	_____ _____ _____
___ Heart Murmur	<u>Immune</u>	_____ _____ _____
___ Heart Valve Replacement	_a_ HIV+/AIDS	_____ _____ _____
___ Heart Stent	a_ Lupus	_____ _____ _____
___ Pacemaker	_a_ Scarlet Fever	_____ _____ _____
<u>Digestive</u>	_a_ Rheumatic Fever	_____ _____ _____
___ Ulcers/GERD	<u>Muscular/Skeletal</u>	Are you taking blood thinners? (i.e. Warfarin (Coumadin), Aspirin, Pradaxa, Xarelto, Plavix, or Other?) <input type="checkbox"/> Yes <input type="checkbox"/> No
___ Hepatitis	aaaTj gwo cvqkf "Ctjv tkku	If Other, please name? _____
<u>Gct IP qugIVj t qcv</u>	aaaQuqgctjv tkku	If yes, what/when was the most recent INR? _____ / _____
___ Hearing Loss	aaaIqkpvTgr mrego gpv	Are you or have you taken bone strengthening drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Endocrine</u>	<u>Other</u>	Presently under a Physiician)u"ectgAaaaaYes <input type="checkbox"/> No <input type="checkbox"/>
___ Diabetes	___ Organ Transplant	NcuV'O gf kcn'Xkukv"Y j gp"aaaaY j { Aaaaaaaaaaaaaaaaaaa
<u>Eyes</u>	___ Radiation Treatment	_____ _____ _____
___ Vision Loss	___ Tobacco Use	<u>Urinary</u>
___ Wear Glasses/Contacts	<u>Respiratory</u>	___ History of Kidney Disease
<u>J go cvqmi { IN{o rj cvle</u>	___ Asthma	<u>Nervous</u>
aaaAnemia	___ COPD	___ Seizures
aaaExcessive Bleeding	___ Chronic Bronchitis	
	___ Tuberculosis	

**Important Notice**

UMMC Dental Mission providers may not be able to provide you with all the services you need, but if you would like to consult with our team and receive the type of treatment being offered today, **PLEASE READ THE PATIENT WAIVER BELOW VERY CAREFULLY.**

**Dental Patients Note:** I understand that because of the number of people needing to be seen, I might not receive multiple extractions or multiple fillings. I understand that I might have certain medical conditions which would keep me from having the type of treatment I am requesting. I also understand that many of the dental care providers are volunteers, some from out of town, and are not available for follow-up care in the event of complications. Follow-up care is available through the School of Dentistry.

In consideration of the free dental care services received on the date below, I for myself and anyone entitled to claim through me, do hereby waive and release the University of Mississippi School of Dentistry, and any other organization or company or persons acting on their behalf or sponsoring or volunteering at this clinic, from all claims of liability arising out of my acceptance of such free care including but not limited to medical, surgical, dental, and/or vision care or other health care or medical advice.

I grant to the School of Dentistry at the University of Mississippi and its agents the right to use my picture, voice and other reproductions of my physical likeness in connection with advertising or publicizing UMMC Dental Mission Week services and its activities in all forms of media in perpetuity.

I have read, or had read to me, and understand and agree to all of the above.

\_\_\_\_\_  
Patient signature (parent or guardian if patient is under 18 years or age)      Date

If under 18, please print guardian's name

\_\_\_\_\_

Is guardian also receiving treatment today?  Yes /  No

**If yes, name of Guardian:** \_\_\_\_\_

SIGN HERE

**AUTHORIZATION FOR THE RELEASE OF  
PATIENT'S NAME, IMAGE, PROTECTED HEALTH INFORMATION BY  
THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER**

Patient's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_  
P.O. Box, Apt. No., Street City State Zip

I, \_\_\_\_\_ (name of parent or guardian) on behalf of myself and \_\_\_\_\_ (name of patient), my child/ward, hereby permit and authorize the University of Mississippi Medical Center (U M M C ) and its employees, agents, and personnel who are acting on behalf of the University of Mississippi Medical Center and its affiliated entities to use my child/ward's name, image (photo, video and/or audio), or other likenesses of my child/ward, and protected health information (PHI) including name, age, hometown, biographical information, diagnosis, health care treatment and prognosis on news and marketing items, including, but not limited to, feature stories, social media content, photo and video essays, all forms of advertising and press releases produced by UMMC.

I understand that my child/ward's name, art work, photograph, video image or other likeness and PHI may be copied and distributed to various media outlets, including but not limited to newspapers, wire services, the digital and broadcast media, video presentations, press releases, mailouts, electronic and static outdoor boards or signs, brochures, presentations or placement on UMMC websites. I hereby release, discharge, and agree to hold harmless UMMC from any and all claims, damages, liabilities, costs and expenses that I or my child/ward now have or may hereafter have by reason of any use of my child/ward's image, likeness or PHI.

I understand that UMMC and affiliated entities and its employees, agents and personnel acting on its behalf, cannot warrant or guarantee that use of my child/ward's name, photograph, video image, likeness, or health or medical care information by the media and further dissemination of my name, photograph, video image or likeness, or health or medical care information will be subject to UMMC supervision and/or control. Accordingly, I release the University of Mississippi Medical Center, its employees, agents and personnel acting on its behalf from any and all liability related to dissemination of my child/ward's name, photograph, video image, likeness, health or medical care information.

Unless otherwise indicated or revoked by the patient or Legal Representative (if patient is under the age of 18 or unable to sign), permission for UMMC and its affiliated entities to release the information expires 25 years after the date this authorization is signed. You have the right to revoke this authorization at any time. If you do so, it does not affect the information that has already been released or is currently in the process of being printed or distributed. To revoke your permission, send a written notice, which has been signed and dated by the patient whose authorization it is (or their Legal Representative), to UMMC at the following address: Attention: Office of Compliance, The University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216-4505. The notice should have the following information on it: (1) the patient's name; (2) a description of the information and material about you that UMMC had permission to release; (3) the name or other specific identification of the media, person(s), or class of persons, to which the Medical Center was going to send the information to (if known); and (4) the date that the permission was signed.

You may refuse to sign this Authorization. UMMC will not refuse to treat you if you do not sign this form.

I have carefully read and understand the above, and do herein expressly and voluntarily sign this authorization. I may receive a copy of this signed authorization at my request.

\_\_\_\_\_  
Signature of Patient or Legal Representative  
(Form must be completed before signing)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
Signature of University of Mississippi Medical Center Representative

\_\_\_\_\_  
Date



THE UNIVERSITY OF MISSISSIPPI  
**MEDICAL CENTER**  
 EDUCATION • RESEARCH • HEALTHCARE

Medical Record Number

**Acknowledgement of Receipt  
 of Notice of Privacy Practices**

I agree that I have received a copy of the UMMC Notice of Privacy Practices.

SIGN HERE

Print patient's name \_\_\_\_\_ Date \_\_\_\_\_

SIGN HERE

Signature of patient or representative \_\_\_\_\_

Description of personal representative's authority \_\_\_\_\_

**UMMC Use Only**

*The following should be completed only if the patient cannot sign or refuses to sign the acknowledgement*

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but UMMC was unable to obtain acknowledgement because:

\_\_\_\_\_

Employee signature \_\_\_\_\_ ID number \_\_\_\_\_

Date \_\_\_\_\_



THE UNIVERSITY OF MISSISSIPPI  
**MEDICAL CENTER**  
EDUCATION • RESEARCH • HEALTHCARE

## NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2015

**This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

UMMC creates a record of the care and services you receive from us. We call this record your health information. We are required by federal law to keep your health information private. We are also required to provide you with this Notice so that you will know how we use and release your health information. This notice also lists the rights you have regarding your health information. We will abide by the terms of the notice. This Notice covers your care provided at UMMC sites of service.

We reserve the right to change the terms of this notice and our privacy practices at any time. Any changes will apply to the health information we already have. When we make changes to our privacy practices, we will post an updated notice in the places where you may get treatment from UMMC. You can also request a copy of this notice at any time, and you may view a copy of the notice on our web site at [www.umm.edu](http://www.umm.edu).

### HOW UMMC MAY USE AND RELEASE YOUR HEALTH INFORMATION

#### Uses and Releases Relating to Treatment, Payment, or Health Care Operations (TPO) & Notice of Distinct Uses and Releases for TPO

**For Treatment.** For example, a doctor treating you for chest pain may need to know if you have any existing heart problems so that he/she can make an informed decision concerning your treatment. Additionally, we will/may contact you to (1) remind you of your appointment by calling or mailing a postcard; or (2) discuss treatment alternatives or other health related benefits that may be of interest to you as a patient.

**To Obtain Payment for Treatment.** For example, we will release some of your health information to your health insurance company in order to receive payment for your treatment.

**For Health Care Operations.** For example, administrative personnel or others that perform services for UMMC may review your health information to review the quality and appropriateness of the care you receive.

**For Fundraising Activities.** We may contact you about UMMC fundraising activities. You will have the opportunity to opt out of any fundraising material and directions to do so will be included in that material. Your treatment does not depend on whether you decide to opt out of fundraising material or not.

**Health Information Exchanges.** We may make your health information available electronically to other healthcare providers or other healthcare entities for treatment, health care operations, or payment purposes by a state, regional, or national information exchange service. In doing this, we may receive information that they maintain about you so that you may have continuity in health care, treatment, or payments for health care services.

#### Uses and Releases That Do Not Require Your Permission

**Emergencies.** We may use or release your health information in an emergency treatment situation.

**Food and Drug Administration.** We may use and release your health information to a person or company required by the Food and Drug Administration to track adverse events and as otherwise required.

**Workman's Compensation.** We may use and release your health information as necessary to comply with workman's compensation laws and other similar legally-established programs.

**Federal, State or Local Law.** We may use and release your health information when required by law.

**Government Agencies and Law Enforcement.** We may release your health information to government agencies and law enforcement.

**Ordered by a Court, Tribunal or Other Judicial Proceeding.** We may release your health information when ordered by a court, tribunal or other judicial proceeding.

**Public Health Reasons.** We may use or release your health information for public health reasons.

**Coroners, Medical Examiners and Funeral Home Directors.** We may release your health information to a coroner, medical examiner or funeral home director.

**Health Oversight Reasons.** We may release your health information to the government to be used to oversee the healthcare system.

**Organ and Tissue Donation.** We may use and release your health information for organ and tissue donation.

**Research Reasons.** We may release your health information for reviews to prepare a research study and when approved by an institutional review board.

**Disaster Relief Reasons.** We may release your health information for the reason of coordinating disaster relief efforts.

**Specialized Government Functions.** We may release the health information of military personnel and veterans in certain situations to the government. We may also release your health information for national security reasons.

**Avert a Serious Threat to Health or Safety.** We may release your health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person, such as instances of child and/or elderly abuse or neglect.

**De-identified Protected Health Information.** We may use or release your health information when it has been de-identified in compliance with HIPAA laws. De-identified information does not contain information that could be used to identify you.

## Uses and Releases to Which You Have the Opportunity to Object

**People Who Help Take Care of You.** We may provide your health information to a family member, friend or other person, if they help take care of you, or if they are responsible for paying for your care, unless you tell us not to. In emergencies, you will not be given the chance to tell us not to provide information to those who take care of you.

**Hospital Directory.** If you are admitted to one of our hospitals or units, your name, location within the hospital and religious affiliation will be listed in the hospital directory, unless you tell us not to list you. This information may be released to persons who ask for you by name, such as family and friends, and to members of the clergy.

## Other Uses and Releases Require Your Prior Written Permission

**Psychotherapy Notes.** Psychotherapy notes that may be written by a mental health professional regarding the contents of conversation held within a counseling session and are stored separately from the rest of your health information. Such notes will not be released unless both you and your provider agree.

**Marketing.** Marketing information typically may only be used or disclosed by UMMC if you provide UMMC with written permission to use or disclose your information.

**Sale of PHI.** We do not sell your health information.

Other uses and releases will be made, of your health information, only with your written permission. You may take back permission once you have given it and your refusal to provide permission will not be held against you; however, it may prevent us from completing a task you have requested, such as enrollment in a research study or to create a report for your attorney. The request to take back the permission must be made to UMMC in writing. You cannot take back permission if UMMC has already acted in reliance of the permission and as needed to maintain the integrity of a research study.

## YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

**You have the right to see and to get copies of your health information.** With only a few exceptions, you have the right to look at, or get hard copies or, with certain limitations, electronic copies of your health information that we have. You must make this request in writing. If we do not have your health information, but we know who does, we will tell you how to get it. We will respond to you within 30 to 60 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. If you request copies of your health information, we may charge you a fee based on our cost. Instead of providing the health information you requested, we may provide you with a summary or explanation of the health information as long as you agree to accept a summary and to the cost in advance.

**You have the right to request a correction to your health information.** If you believe that your health information is incorrect or information is missing, you may request that the information be changed or added. You must make the request in writing. You must also give us a reason for your request. We will let you know if we accept your request within 60 days of receiving your request. Under certain circumstances, we may deny the request. If we deny your request, we will let you know why. We will also explain your right to file a written statement of

disagreement with the denial. If we approve your request, we will make the change to your information. We will let you know when the change is made. We will also let concerned parties know when the change is made.

**You have the right to request a listing of releases we have made of your health information.** You have the right to an accounting of all entities that obtained information unrelated to treatment, payment, or healthcare operations without your permission, except as otherwise required by law. We will respond within 60 days of receiving your request. Your request must state the time period desired for the accounting, which must be less than a six-year period and starting after April 14, 2003. The list will contain the date of the release, the name of the recipient and address, if known, a description of the information released, and the reason for the release. If you make more than one request in the same year, you will be charged a fee based on cost for each additional request.

**You have the right to request limits on uses and releases of your health information.** You have the right to request a limit on the health information we use or release about you for treatment, payment or health care operations. UMMC will agree to all requests to limit releases of health information to a health plan when you have paid out of pocket in full for the healthcare item or service. All other requests will be considered and we are not legally required to accept them. If we accept your request, we will put any limits in writing and abide by them, except in some situations, such as during emergencies. You may not limit the uses and releases that we are legally required or permitted to make.

**You have the right to choose how we communicate with you.** You have the right to request that we communicate with you in a certain way. For example, you may request that we contact you by phone rather than by mail. We will agree to the request as long as we can easily provide it in the format you request. We require that you make requests for confidential communications in writing.

**You have the right to receive notification in the event your health information is breached.** In the event your unsecured protected health information is breached, we will notify you of the occurrence.

If you would like more information on accessing, obtaining a copy or obtaining a listing of the releases that we have made of your health information, you may call the following number: 1-855-241-2575

**MS State Law:** In some instances, Mississippi law is more limited than Federal law. Please contact the UMMC Privacy Officer if you have any questions regarding MS state privacy laws.

## FILING A COMPLAINT

If you have any questions about this notice, complaints about our privacy practices or would like information on how to file a complaint with UMMC or the Secretary of the Department of Health and Human Services, please contact: the UMMC Privacy Officer, at The University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216 or call the Compliance Hotline at 601-984-4722. You will not be penalized or retaliated against for filing a complaint.