Johnson County Community College - Oral Health on Wheels

Patient's Bill of Rights and Policies

The faculty, staff and students, at Johnson County Community College - Oral Health on Wheels clinic strive to provide high quality care in a pleasant teaching atmosphere. All of our patients are entitled to:

- Considerate and respectful treatment in a clean and safe environment
- Receive treatment without discrimination as to race, color, religion, sex, nationality, disability, sexual orientation or source of payment
- Continuity and completion of dental hygiene care that meets the professional standard
- Access to complete and current information about his/her oral conditions
- Receive information that is needed to give informed consent for any proposed treatment procedure or treatment
- An explanation of the recommended dental hygiene treatment, treatment alternatives and the expected outcome
- Refuse treatment and be told what effect this may have on their oral health
- Confidentiality regarding all medical and oral conditions, and patient records

The Oral Health on Wheels clinic provides limited services. OHOW staff dentists will give written referrals for recommended further treatment needs and services. Patients are encouraged to maintain a dental home, seeking regular preventive visits.

All patients will be informed if there is a need for a medical consultation before dental treatment can be provided. Treatment in the Oral Health on Wheels may be denied or delayed based on certain medical conditions.

The JCCC Oral Health on Wheels clinic is in compliance with the federal Health Insurance Portability and Accountability Act (HIPPA). Confidentiality of individual records is maintained. Only members of the JCCC faculty, staff and students with a legitimate need are allowed access to patient records. Release of patient records requires the individual's written consent.

CONSENT FOR TREATMENT AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT

NAME____DATE____________________________

ADDRESS____

Electronic address ____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out dental treatment, health care operations, and delivery of x-rays by electronic means.

Right to Revoke: You will have the right to revoke this Consent at any time by giving written notice to JCCC- OHOW clinic of your revocation.

Patient Signature____Date__________

<u>If this consent is signed by a personal representative on behalf of the patient, complete the following:</u>

Personal Representatives' Name: ____________________________________Phone Number ______________

Relationship to Patient: ____Date____________________