CARE AGREEMENT for Patients Under 21 Years of Age

This form contains facts you should know about your health care at University of Washington School of Dentistry. If there is any part of this form that is unclear you can ask question about it. At the bottom of the form there is a place for you to sign your name so that we know you have read this form (or had it read to you) and agree to receive health care from us.

UW School of Dentistry includes:

- Pre-Doctoral Student Clinic
- Graduate Student Clinics
- UW Dentists Faculty Practice
- Advanced General Dentistry
- TMJ & Oral Medicine
- Dental Education in Care of Persons with Disabilities
- The Center for Pediatric Dentistry
- Dental Fears & Research Clinic
- Oral & Maxillofacial Surgery
- Endodontics
- Orthodontics
- Periodontics
- Prosthodontics
- Dental Urgent Care

Your health care team consists of licensed faculty dentists, dentists in advanced training programs, dental students and other health care professionals. They will work together to diagnose and treat you. Photographs, videotapes, or other images of you may be used to keep a record of your care and treatment (including surgery). These images may become part of your dental record.

Patient Rights and Responsibilities

- Patients have the right to impartial, reasonable access to care and treatment regardless of one’s race, color, creed, religion, sex, sexual orientation national origin, disability, age, or status as a disabled veteran.
- Patients have the right to care that is considerate and respectful of their cultural and personal values and beliefs.
- Patients have the right to have reasonable access to an interpreter or other language assistance if they do not speak or understand the English language.
- Patients have the right to a reasonably safe and secure environment.
- Patients have the right to be free from all forms of abuse or harassment.
- Patients and/or their legally authorized surrogate decision maker(s) have the right, in collaboration with their dentist, to be informed and make decisions involving their dental care, including the right to accept or to refuse dental treatment and to be informed of the consequences of such refusal.
- Patients have the right to be fully informed of their dental needs and the alternatives for care and to be referred elsewhere when the School cannot provide the care a patient needs.
- Patients have the right to effective pain management. Pain will be addressed and managed as deemed appropriate by the care provider.
- Patients have the right to consideration for their personal privacy and confidentiality of information.
- Patients can expect that services rendered in the School meet the standard of care of the dental profession.
- Patients have the right to have access to a written statement that articulates the rights and responsibilities of patients.
- Patients have the right to have access to their dental record during normal business hours, or to obtain a copy of the record at reasonable costs of duplication.
- Patients have the right to make complaints regarding their care according to the established policy and guidelines available in all patient care clinics.
- Patients have the right to request and receive an itemized and detailed explanation of their bill for services rendered.
- Patients have the right to expect that appointments will be offered to them on a regular basis until the completion of their care, once they begin the care process.
• Patients of record have the right to access services for urgent care at the School or to obtain a referral if necessary.
• Patients have the responsibility to provide, to the best of their knowledge, accurate and complete information and to report any changes in their medical status to their care provider.
• Patients have the responsibility to participate in discussions about their plan of care, ask questions, and to inform the care provider if they do not understand proposed treatment.
• Patients have the responsibility for following the treatment plan to which they agreed, including any recommended follow-up instructions.
• Patients have the responsibility to make and keep appointments, arrive on time, stay for the entire time scheduled, and provide a minimum of 24 hours notice to change or cancel appointments.
• Patients have the responsibility for making necessary arrangements for childcare as the School does not provide childcare. Children are not allowed into the treatment areas except for their own appointments, and may not be left unattended in the waiting areas.

Patients have the responsibility for following the School of Dentistry policies and guidelines affecting patient care and conduct: Including all medical and dental history information.

1) Patients may not disrupt or interfere with their care provider, other patients, or the operations of the patient care and office areas.
2) Patients may not conduct any illegal activities on the premises of the School of Dentistry.
3) Patients may not engage in any discriminatory or sexually harassing behavior toward staff, students or faculty per University policy.
4) Patients are responsible for being considerate of the rights of others.
5) Patients are responsible for being respectful of the property of other persons and the School of Dentistry.

• Patients have the responsibility for providing updated, accurate insurance and billing information (including name, mailing address, phone number, and any other requested information for billing purposes), and for meeting the financial obligation agreed to with the School.
• Patients are responsible for letting care providers know if they have complaints or concerns by reporting any complaints or concerns to their care provider or patient advocate, who will then contact the appropriate personnel.

Information for Patients

The information below contains facts you should know about your dental care at the University of Washington School of Dentistry. If there is any part of this information that is not clear, please ask questions.

Your Care Provider:
When you receive care from pre-doctoral dental students and/or graduate students/residents in training, all treatment is supervised by licensed dentists at the appropriate level for the care being provided. These dentists are faculty at the School and will work together with the student provider to diagnose and treat you.

Dental Appointments:
In the pre-doctoral clinics, appointments are scheduled from 9:30 a.m. - 12:00 noon and 1:30 - 4:00 p.m. Appointment availability may be limited when school is not in session. Appointments times in the graduate clinics and UW Dentists Faculty Practice vary. Patients need to be available for the entire appointment. There is a charge for appointments cancelled with less than 24 hours’ notice. Cancellation of three appointments or failing twice to notify a student you want to cancel an appointment may result in discontinuation of your care.
Payment for Services:
Payment is due at the time of service. The School accepts cash, check, Citi Health Card, Visa, MasterCard and Discover Card. Please provide your dental insurance information upon registering as a new patient. If your insurance is contracted with the School it will be billed, however, you are responsible for the co-pay portion on the date of service.

Limited Care:
Limited treatment is available to patients with referrals from private practices and/or minimal needs depending on student availability.

Imaging:
Imaging, such as x-rays, photographs, and/or videotapes or other images of you may be used for diagnosis, treatment, and/or educational purposes. These images will become a part of your dental record.

General Information:
Dental urgent Care Clinic (pain or discomfort with teeth) from 8am-5pm, 206-543-5850. After hours emergency, 206-598-4000.

Children may not be left unattended in waiting areas and are only allowed in clinics for their own appointments.

In accordance with the Washington Administrative Code Animal Control Policy, the School of Dentistry enforces a no pet policy.

There is a $30 charge for appointments cancelled with less than 24 hours notice.

Several broken appointments may result in discontinuance of care.

Parking is not validated; fees apply. Maps and fee information at http://www.washington.edu/commuterservices/parking

Financial Agreement / Authorization

I agree:
1) That UW SOD may share any financial information I provide to facilitate payment.
2) To assign to UW SOD all insurance benefits payable for services provided.
3) To pay in full at time of service if I do not have insurance coverage for my care.
4) To pay UW SOD for balances remaining after insurance benefits are paid, unless prohibited by law or contract.
5) To pay any coinsurance or deductibles required by the terms of my insurance benefits.
6) To pay for any services not covered by my dental or medical insurance company.
7) To notify UW SOD of changes to my insurance coverage and/or address.
8) That UW SOD may impose reasonable interest, late charges, costs and/or reasonable attorney's fees should my account become delinquent.
9) That any lawsuit for collection of our account may be brought in King County, Washington.
I Understand that:
1) The each UW SOD entity bill separately for their services.
2) If the UW SOD does not contract with my insurance provider, the processing of insurance claims is a service and does not relieve me of my financial obligation.
3) I am responsible for knowing my insurance coverage and benefits.
4) If I present a Washington State Medicaid Provider One Card in the CNP program, I am eligible for examinations, preventive and emergency care, and basic restorative service (fillings). Certain procedures require preauthorization before the onset of care, and in this case, treatment may be delayed until the authorization is received.
5) Medicare covers limited dental procedures and only when related to a medical condition.
6) Checks returned unpaid by my bank are subject to a $25 service fee, and must be cleared with guaranteed funds.
7) Certain procedures, such as crowns, inlays, onlays, dentures and bridgework, require an advance deposit. My care provider will inform me of these procedures when discussing my plan of care.
8) Insurance claims remaining unpaid after eight (8) or more weeks are payable in full by me.

Statement to Permit Payment of Medicare/Medicaid or Insurance Benefits to Provider

I request payment of authorized Medicare/Medicaid benefits for any services furnished to me by UW SOD to be made payable directly to UW SOD. I authorize any holder of medical and other information about me to release to Medicare/Medicaid or other Insurance and its agents any information needed to determine these benefits or benefits for related services.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

The UW School of Dentistry Clinics and Faculty Practice Plan Notice of Privacy Practices describes how dental and medical information about you may be used and disclosed, how you can get access to this information, and which procedures you may use if you have questions, concerns or complaints.

We are required by law to protect the privacy of your information, provide the Notice of Privacy Practices, and follow the information practices that are described in this notice. If you have any questions, please contact: UW School of Dentistry Privacy Office 206-685-1022.

Please do not write comments on this form. Refer to the "School of Dentistry Clinics and Faculty Practice Plan Notice of Privacy Practices" brochure for instructions to make special requests about your Privacy Rights.

Note: We may change our policies at any time. Any significant policy change will be posted. You may request a copy of this notice from the UW School of Dentistry Privacy Office or at http://www.dental.washington.edu/programs/compliance/privacy-practices.html
By signing below, I agree that I have received the UW School of Dentistry Clinics and Faculty Practice Plan Notice of Privacy Practices, Care Agreement, Patient Rights and Responsibilities and Financial Agreement / Authorization. Furthermore by signing below, it shows that you have read this document and agree to receive health care from UW School of Dentistry. If there is any part of this form that is unclear, be sure to ask question about it.

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IF SIGNED BY PERSON OTHER THAN PATIENT, CHECK RELATION TO PATIENT:

- [ ] 1. Guardian
- [ ] 2. Durable Healthcare Power of Attorney
- [ ] 3. Spouse/Registered Domestic Partner
- [ ] 4. Adult Child(ren)
- [ ] 5. Parent(s)
- [ ] 6. Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:

- [ ] 1. Guardian/Legal Custodian
- [ ] 2. Court-authorized person for child in out-of-home placement
- [ ] 3. Parent(s)
- [ ] 4. Holder of signed authorization from parent(s)
- [ ] 5. Adult representing self to be a relative responsible for the minor’s health

FOR OFFICE USE ONLY: REMARKS for the UW School of Dentistry Clinics and Faculty Practices Plan Notice of Privacy Practices:

(This section below is to be filled out by UW School of Dentistry staff only)

We are unable to obtain acknowledgement from this individual at this time, but immediate treatment is needed for the following reason(s):

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UW School of Dentistry
Workforce member

Signature: ___________________________ Date: ___________________________