PREMIER
Community HealthCare

Dear Parent/Guardian,

Your child's school will be visited by staff of Premier Community HealthCare Group in a joint effort with Pasco County Public Schools to provide dental screenings/ cleanings, fluoride varnish and sealants for students.

In order for the child to receive dental services from PCHG, a Patient Data Form and Consent to Treat must be completed in its entirety and bear the signature of a parent or guardian.

Please complete, sign and return these forms to your child's teacher immediately. Parents/Guardians do not have to be present when services are provided. Our staff will send written communication home with your child after s/he has been seen by our provider.

Please feel free to contact our office at 352-518-2000, if you have any questions. We look forward to seeing your child soon!

Sincerely,

Joseph Resnick, MHA, FACHE
Chief Executive Officer

PREMIER
Community HealthCare

Mission: To provide accessible healthcare services for all.
Vision: A community where everyone is healthy.

Parent/Guardian Permission for Dental Services

__Yes, I give permission for my child to receive routine dental services (dental screenings/cleanings, fluoride varnish and sealants, as indicated) provided by Premier Community HealthCare Group, Inc. at my child's school. I understand that these dental services are being provided by Premier Community HealthCare Group and not by the Pasco County Public Schools.

__ No, I do not give permission for my child to receive dental care from Premier Community HealthCare.

School: _____ Teacher: _____ Grade: _____

Name of Child: _____ Age: _____
First Middle Initial Last

Date of Birth: _____ Sex: _____

Insurance #: _____ Cost for Uninsured Child: $20.00

My Child has a dentist: Yes (Name of Dentist)_____ No _____

Child's Health History

Yes ☐ No ☐ Has your child received a dental check-up or dental care within the last year?

Yes ☐ No ☐ Is your child allergic to anything? If yes, please list: _____

Yes ☐ No ☐ Has your child been seriously ill? If yes, please explain: _____

Yes ☐ No ☐ My child is taking the following medications: _____ for: _____

Yes ☐ No ☐ My child needs to take antibiotics (i.e penicillin) before dental care? _____

Yes ☐ No ☐ My child has the following health problem: _____

My signature below indicates my consent for my child to receive any of the above services, as well as those services listed on the reverse side of this document. My signature also indicates my acceptance of the those conditions specified on the reverse side of this document.

I certify that I have READ and UNDERSTAND the above questions. I have answered the questions to the best of my knowledge and have had any questions regarding my child answered. I understand that my child is not being provided other dental care that s/he may need. I understand that this dental program will be provided by Premier Community HealthCare Group, Inc. at my child's school. On behalf of myself and/or the patient, I authorize Premier Community Health Care Group, Inc., to disclose patient information for the purpose of receiving payment from any third party payer that covers the services provided to this patient. If my child is uninsured, I agree to pay a flat rate of $20 for those services for my child.

Print Parent/Guardian's Name: _____ Phone No: _____

Parent/Guardian's Signature: _____ Date: _____

PREMIER
Community HealthCare

Initiation of Services

PART I CLIENT-PROVIDER RELATIONSHIP CONSENT
Client Name: **ON REVERSE SIDE**
Name of Agency: Premier Community HealthCare Group, Inc.
Agency Address: 37912 Church Avenue, Dade City, FL 33525
I consent to entering into a client-provider relationship for the individual listed on the reversed side of this document. I authorize Premier staff and their representatives to render routine health care. I understand rountine health care is confidential and voluntary and may involve medical/dental office visits including obtaining medical/dental history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue the relationship at any time. I may withdraw my consent at any time by a written withdrawal given to the Provider.
PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only) I consent to the use and disclosure of my medical information, including medical and dental; for treatment, payment and health care operations. I also consent to the limited disclosure of my child's information to the School/School Nurse as may be needed for the purposes of follow up care.
PART III ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers) As Client/Representative signed on reverse side of this page, I assign to the above named agency all benefits provided under any health care plan or medical expense policy and authorize agency to disclose necessary information for payment purposes. The amount of such benefits shall not exceed the medical/dental charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency.
PART IV My signature below verifies the above information and receipt of the notices of Privacy Rights.
Your signature at the bottom on the reverse side serves as consent to this section.

Pasco County Schools
Kurt S. Browning, Superintendent of Schools
7227 Land O' Lakes Boulevard • Land O' Lakes, Florida 34638

HOLD HARMLESS, INDEMNIFICATION, AND RELEASE AGREEMENT

This agreement is a waiver, release, indemnification agreement, and hold harmless, which acts to release the District School Board of Pasco County, its individual members, schools, personnel, employees, agents and assigns (hereinafter collectively referred to as School Board) from any and all judgments, attorney fees, costs, payments, medical bills, damages, claims, suits or other expenses which may result from the use of School Board property by Premier community HealthCare Group, Inc., (hereinafter PCHG) for the purposes of providing dental health services. Parent/guardian agrees to release and hold the School Board harmless for any injuries, damages, suits or claims, arising out of this matter, regardless of whether such injuries or damages arise out of the accidental, negligent or reckless acts of PCHG or School Board, its employees, subcontractors, agents and assigns. Parent/guardian understands that, for the purposes of this agreement, participation in the event, and the protections afforded to PCHG by this agreement, not only extends to and includes the service provided but also encompasses any other acts while on School Board property that are directly or indirectly related to the event

Your signature at the bottom on the reverse side serves as consent to this section.

Premier Community HealthCare Group, Inc.
Patient Information Form

Patient Information

1. Name _____ Date of Birth: _____
2. Address: _____ Apartment: _____
3. City: _____ State: _____ Zip Code: _____
4. Home Phone: _____ Cell Phone: _____ Work Phone: _____
5. E-mail Address: _____
6. Marital Status: ▫ Single ▫ Married ▫ Divorced ▫ Widowed
7. Gender: ▫ Female ▫ Male
8. Sexual Orientation (a person's sexual identity in relation to the gender to which they are attracted)
   ▫Lesbian/Gay ▫Straight (not lesbian/gay) ▫Bisexual
   ▫Something Else ▫Don't Know ▫Choose not to disclose
9. Gender Identity (a person's perception of having a particular gender, which may or may not correspond to the gender they were at birth.)
   ▫Male ▫Female ▫Transgender Male(Female-to-Male)
   ▫Transgender Female(Male-to-Female) ▫Other ▫Choose not to disclose
10. Race: ▫ White ▫ Black ▫ Am. Indian/Alaskan Native ▫Native Hawaiian ▫Other Pacific Islander
    ▫ Asian ▫More than one race
11. Ethnicity: ▫ Hispanic/Latino ▫Not Hispanic/Latino Preferred Language: _____
12. Employment Status:
    ▫Employed ▫Self Employed ▫Unemployed ▫Disabled ▫Retired
    ▫Full Time Student ▫Part Time Student
    Employer/School Name: _____
13. Are you a military veteran? ▫Yes ▫No
14. Are you homeless? ▫Yes ▫No
    If yes, choose one: ▫Shelter ▫Living with friend/doubling up ▫Street/Car ▫Transitional ▫Other
15. Do you have health insurance? ▫Yes ▫No If yes, name of insurance? _____
16. Do you have internet access? ▫Yes ▫No

17. Parent/Legal Guardian Information: (complete only if patient is a minor)
    Mother's Name: _____ Date of Birth: _____ Gender: ▫Male ▫Female
    Father's Name: _____ Date of Birth: _____ Gender: ▫Male ▫Female
    Guardian's Name: _____ Date of Birth: _____ Gender: ▫Male ▫Female
18. Phone Number: _____ E-mail Address: _____
19. Marital Status: ▫ Single ▫ Married ▫ Divorced ▫ Widowed
20. Race : ▫White ▫ Black ▫Am. Indian/Alaskan Native ▫Native Hawaiian
    ▫Other Pacific Islander ▫Asian ▫More than one race
21. Employment Status: ▫Employed ▫Self Employed ▫Unemployed ▫Disabled ▫Retired
    ▫Full Time Student ▫Part Time Student Employer/School Name: _____

Premier Community HealthCare Group, Inc.
Patient Information Form

22. In the past two years, or prior to retirement or disability:

- Have you or the head of your household worked in agriculture? ▫Yes ▫No
- Did you or the head of your household move from this area to another County or State in search of agricultural work? ▫Yes ▫No
- Has your family lived in this area and earned more than half their income from seasonal agriculture? ▫Yes ▫No

23. Circle your household size and annual household income range. *Information for reporting purposes only.*

Household Size	Annual Household Income				
1	$0 - $11,880	$11,881 - $15,800	$15,801 - $19,721	$19,722 - $23,760	$23,761 - and up
2	$0 - $16,020	$16,021 - $21,307	$21,308 - $26,593	$26,594 - $32,040	$32,041 - and up
3	$0 - $20,160	$20,161 - $26,814	$26,815 - $33,466	$33,467 - $40,320	$40,321 - and up
4	$0 - $24,300	$24,301 - $32,320	$32,321 - $40,338	$40,339 - $48,600	$46,601 - and up
5	$0 - $28,440	$28,441 - $37,826	$37,827 - $47,210	$47,211 - $56,880	$56,881 - and up
6	$0 - $32,580	$32,581 - $43,332	$43,333 - $54,083	$54,084 - $65,160	$65,161 - and up
7	$0 - $36,720	$36,721 - $48,839	$48,840 - $60,955	$60,956 - $73,440	$73,441 - and up
8	$0 - $40,860	$40,861 - $54,345	$54,346 - $67,828	$67,829 - $81,720	$81,721 - and up

24. Premier participates in the 340B Drug Pricing Program. This program is a U.S. federal government program that requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices.

Premier patients can opt to have prescriptions prescribed by Premier providers filled under this program by using one of the following pharmacies. By doing so this will allow you to receive a reduced price for qualified prescriptions.

▫ Walgreens #04811 – 12807 US Hwy 301, Dade City
▫ Walgreens #05414 – 9220 Little Road, New Port Richey
▫ Walgreens #05604 – 6429 Gall Blvd, Zephyrhills
▫ Walgreens #06412 – 28115 State Road 54, Wesley Chapel
▫ Walgreens #11790 – 36515 State Road 54, Zephyrhills
▫ Walgreens #12318 – 2480 US Hwy 19, Holiday
▫ Walgreens #0440 – 8951 Hudson Ave, Hudson

Please check pharmacy above or list the pharmacy preferred: _____

Address: _____ Phone: _____

_____ _____
Patient's Signature **Date**

_____ _____ _____
Signature of Parent or Patient's Representative (if applicable) **Date** **Relationship to Patient**

Office Use Only

Care Team Member Signature: _____ **Date:** _____

PREMIER
Community HealthCare

Patient Name:
Date of Birth:
Account Number:

	Initial	Date
1. Consent for Treatment I hereby consent and authorize treatment at Premier Community Healthcare Group Inc,(PCHG), for myself, the patient.		
2. Consent for Treatment of a Minor I, as the parent or legal guardian, do hereby give my consent and authorization for treatment of my child _____. Furthermore, I grant permission for the following individuals to authorize Medical/Dental treatment in my absence.		
3. Medical Home I choose to participate in the patient centered medical home program.		
4. Release of Information Protected health care information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or any other purpose related to benefit payment. If I am covered by Medicaid, Medicare or other Health Plan, I authorize the release of protected health care information to the appropriate agency for payment of the claim. The information may include, without limitation, history and physical, emergency records, laboratory reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other health care providers, insurers, and/or health care industry participants and their subcontractors In order for these individuals and entities to share my health information with one another to accomplish goals that may include but not limited to: improving the accuracy and increasing the availability of my health records, decreasing the time needed to access my information, continuity of care; and such other purposes as may be permitted by law. I understand this facility may be a member of such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases such as HIV and AIDS. I hereby authorize the practice and the physicians or other health professionals involved in my care to release health care information for purposes of treatment, payment and/or health care operations.		
5. Disclosure to Family Members and/or Friends I give permission for my protected health information to be disclosed for purposes of coordination health care needs, communicating results, findings and care decisions to the family members and/or friends listed below:		

Name	Relationship	Contact Number

** You have the right to revoke whom we talk with about your health care at anytime. You must sign a new consent.

6. Emergency Contact Name / Relationship / Contact Number _____ / _____ / _____		
	Initial	Date
7. Consent to use Electronic Mail (E-mail) or Text Message for Appointment Reminders and Other Health Care Communications. If at anytime I provide an email address or mobile phone number at which I may be contacted, I consent to receiving appointment reminders and other health care communications/information at the email address or mobile number provided. Mobile Number:_____ Email Address: _____		
8. Revocation □ I hereby revoke my request to receive any future appointment reminders, feedback and general health via e-mail messaging. □ I hereby revoke my request to receive any future appointment reminders, feedback and general health via text messaging.		
9. Patient Rights & Responsibilities, HIPAA, Financial Policy & Patient Centered Medical Home These documents are posted in the lobby and on our website: www.premierhc.org. I acknowledge that I have received or have been allowed to view a copy of each and understand and agree to the terms set forth in the policies.		
10. Notice of Policy Regarding Advanced Directives (for patients over 18 years of age) Advanced Directives are legal statements that indicate the type of medical treatment desired or not desired in the event an individual is unable to make decisions as well as who is authorized to make them. Advance directives are made and witnessed prior to serious injury or illness. In accordance with federal and state law, this serves as notification that we will set aside your advanced directives in the event you experience a life threatening event while at one of the PCHG locations and you will be transferred to a higher level of care, i.e. hospital. Please indicate below whether or not you have an advanced directive or if you would like to receive information on advanced directives. □ I have an advanced directive. □ I do not have an advanced directive. □ I would like to receive information on advanced directives.		
11. Residents and Students I understand that Premier Community HealthCare Group, Inc., supports education of medical/dental professionals and maintains residents and students that may assist in relation to your care.		

By signing below, I agree and understand this notification.

_____ _____

Patient Signature Date

_____ _____

Signature of Parent or Patient's Representative Date

Office Use Only

Care Team Member Signature: _____ **Date:** _____

SUMMARY OF THE FLORIDA

PATIENT'S BILL OF RIGHTS

FLORIDA LAW REQUIRES THAT YOUR HEALTH CARE PROVIDER OR HEALTH CARE FACILITY RECOGNIZE YOUR RIGHTS WHILE YOU ARE RECEIVING MEDICAL CARE AND THAT YOU RESPECT THE HEALTH CARE PROVIDER'S OR HEALTH CARE FACILITY'S RIGHT TO EXPECT REASONABLE BEHAVIOR ON THE PART OF PATIENTS. YOU MAY REQUEST A COPY OF FULL TEXT OF THAT LAW FROM YOUR HEALTH CARE PROVIDER OR HEALTH CARE FACILITY. A SUMMARY OF YOUR RIGHTS AND RESPONSIBLITIES ARE AS FOLLOWS:

A PATIENT HAS THE RIGHT...

- To be treated with courtesy and respect, with dignity, and with protection of his/her privacy.
- To confidential handling of medical records, and except when required by law, to be given the chance to approve or refuse their release.
- To know who is providing medical services and care. *To know who your medical home team is and that they will work together to explain the things that are important to you, and to support you every step of the way.*
- *To know how to reach their medical home after hours.*
- To be treated for any emergency medical condition that will deteriorate from failure to provide treatment.
- To impartial access to medical treatment or accommodations, regardless of race, color, sex, national origin, disability, religion age, sexual orientation or source of payment.
- To know what patient support services are available, and whether or not an interpreter is available if (s)he does not speak English.
- To be given by the health care provider information concerning his/her diagnosis, evaluation, treatment plans, risks, prognosis, choices and to be given prompt response to questions and requests.
- To refuse any treatment except as otherwise provided by law.
- To know upon request and in advance of treatment whether the health care provider or health care facility accepts the Medicare or Medicaid assignment rate.
- To know if medical treatment is for purposes of experimental research and to give his/her consent or refusal to participate in that research.
- To be given upon request and prior to treatment, a reasonable estimate of fees for medical care, full information and necessary counseling on financial resources available for medical care.
- To receive a copy of a clear, understandable itemized bill and upon request, to have charges explained.
- To know what rules and regulations apply to his/her conduct.
- To express grievance of any violation of his/her rights, as in Florida law, through the grievance process of the care provider or health care facility which served him and to the appropriate state agency.

A PATIENT HAS THE RESPONSIBILITY...

- To provide to his/her health care provider, to the best of his/her knowledge, accurate and complete. information about present complaints, past illnesses, hospitalizations, medications including over the counter and dietary supplements, allergies, and other matters about his/her health.
- To report unexpected changes in his/her condition to the provider.
- To report to his/her health care provider if he/she does or does not understand the course of action and what is expected of him/her. *Be sure to know the things you need to work on before your next appointment.*
- To follow the treatment plan recommended by his provider and to take responsibility for his/her actions if (s)he refuses treatment or does not follow the provider's instructions.
- To keep appointments and when (s)he is unable to do so for any reason, to notify the provider or the health care facility.
- To assure that the financial obligations of his/her health care are fulfilled as quickly as possible.
- To follow health care facility rules and regulations affecting patient care and conduct.

AHCA/MEDICAID HOTLINE NUMBER

1(888) 419-3456

2727 Mahan Drive
Tallahassee, FL 32308
http://www.ahca.myflorida.com/

PREMIER
Community HealthCare

2016-2017 Dental Clinic Calendar

Premier Community HealthCare Group, Inc. will be at Gulfside Elementary, providing dental services (cleanings, fluoride varnish and sealants, if applicable) for children on the following dates:

Wednesday's from 10:00am- 3:00pm

September 7, 2016	January 25, 2017
September 14, 2016	February 1, 2017
September 21, 2016	February 8, 2017
September 28, 2016	February 15, 2017
October 5, 2016	February 22, 2017
October 12, 2016	March 1, 2017
October 19, 2016	March 8, 2017
October 26, 2016	March 15, 2017
November 2, 2016	March 29, 2017
November 9, 2016	April 5, 2017
November 16, 2016	April 12, 2017
November 30, 2016	April 19, 2017
December 7, 2016	April 26, 2017
December 14, 2016	May 3, 2017
December 21, 2016	May 10, 2017
January 11, 2017	May 17, 2017
January 18, 2017	May 24, 2017

* March/May dates may change due to FSA Testing. Current Total: 34 weeks