Herman Ostrow School of Dentistry of USC

Faculty Practice

KEEP FOR YOUR RECORDS

The faculty, students and staff at the Herman Ostrow School of Dentistry of USC Faculty Practice are committed to ensuring that you receive the highest quality of care and service.

We have developed a Patient's Bill of Rights and Responsibilities (see the following pages) that reflects our standards for delivery of patient care. While we strive to provide you the highest standards of care, it is possible that you may feel that we have not achieved our goals. If you are dissatisfied with the care you are receiving, we hope that you will bring your concerns to our attention. We are also anxious to hear about positive experiences you have had and any individuals who were particularly competent, helpful, and courteous or who otherwise made your experience in our dental clinic a good one. We welcome any comments or suggestions you may have that will help us to serve you better.

Patient comment forms are available in all clinic offices for your use. Completed forms may be returned to any office or you can mail your comments to the Herman Ostrow School of Dentistry of USC Office of Quality Assurance, 925 West 34th Street, University Park MC 0641, Los Angeles, California 90089-0641.

We are pleased that you have selected the Faculty Practice of the Herman Ostrow School of Dentistry of USC to be your dental care provider and look forward to serving your needs.

Douglas Solow, DDS, MBA

Associate Dean for Clinical Affairs

Nondiscrimination in Services Policy

Admissions, the provision of services, and referrals of patients shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age, or sex.

Services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery locations.

Any patient, parent and/or their guardian who believes they have been discriminated against may file a complaint of discrimination with:

USC's Office of Equity and Diversity
Phone Number: (213) 740-5086

FP 05222014

Herman Ostrow School of Dentistry of USC

Faculty Practice

Welcome to the Herman Ostrow School of Dentistry of USC Faculty Practice. It is our goal to provide each patient with the best possible care throughout the course of his or her treatment. Please carefully review our office policies and feel free to discuss them with our staff.

1. Keep in mind that you are ultimately responsible for any and all charges for treatment rendered, regardless of insurance coverage. We will gladly process your insurance claims (Delta Dental PPO only), and any portion of your treatment not covered by insurance is payable at your appointment. Please be sure that you understand your treatment costs. If you have a question regarding the cost of a procedure, please ask our staff.
2. Patients covered under the USC Delta Dental PPO Plan ("Delta Dental"):
    a. Verify your eligibility with the Delta Dental Plan. Any questions about your eligibility should be directed to the USC Benefits Department.
    b. USC Delta Dental PPO covers 100% of allowable charges up to a $2000.00 maximum per calendar year. Remember that Delta Dental has exclusions in coverage; please review the Evidence of Coverage booklet, which can be obtained from the USC Benefits Department. You are responsible for charges that are not covered by Delta Dental.
    c. Delta Dental covers two (2) hygiene appointments (cleanings) per year. These are not free; their costs are deducted from the annual maximum. If your recommended treatment is more than two (2) cleanings per year, then you will be responsible for the costs of the additional cleaning(s).
    d. All charges that surpass the $2000.00 annual maximum are the responsibility of the patient. Please keep a rrecord f your treatment and costs. This information can be obtained from our staff.
3. Patients covered by another insurance other than the USC Delta Dental plan:
    a. Supply our office with full insurance information on all dental plans.
    b. Please be aware that you may have co-payments for office visits, depending on the insurance coverage.
4. Please arrange for childcare; our staff cannot monitor children during your treatment.
5. A parent must accompany all patients who are under 18 years of age. Due to legal and safety issues, the parent must remain in our office for the duration of the appointment.
6. The patient is responsible for making and keeping appointments. If you need to cancel, please inform our office at least 24 business hours prior to your scheduled visit. You may leave a message on our answering service if you are unable to reach our staff (please also see number eight (8) below).

Patient Initials________

7. In fairness to other patients, we reserve the sole right to reschedule your appointment if you are more than 15 minutes late, depending on the circumstances.
8. Failure to inform our office of a cancellation at least 24 business hours prior to an appointment, or arriving late for an appointment that results in your being rescheduled, is considered a "missed appointment", which may result in a $50.00 fee. This fee must be paid by you before scheduling another appointment. Insurance companies do not cover missed appointment fees. The Faculty Practice attempts to make courtesy confirmation calls; however, the lack of receipt of a call does not change this policy.

______________________________   ____________________

Patient/Parent/Guardian Signature   Date

____

Print Name

Patient Initials________

Herman Ostrow School of Dentistry of USC

Faculty Practice

INSURANCE ACCEPTANCE POLICIES

The Herman Ostrow School of Dentistry of USC Faculty Practice is a contracted provider for Delta Dental* Insurance Company and the USC Network Medical Plan ONLY. We will bill these insurance companies for treatment rendered. However, the patient is ULTIMATELY responsible for all fees and costs associated with their treatment.

IF INSURANCE PAYMENT IS DENIED OR PAYMENT HAS NOT BEEN RECEIVED WITHIN 90 DAYS FROM THE FACULTY PRACTICE'S CLAIM SUBMISSION TO THE INSURANCE COMPANY, THE PATIENT WILL BE BILLED FOR THE BALANCE DUE.

The Faculty Practice does NOT bill or submit insurance claims or any other claims for other insurance carriers and/or payers. Payment is expected when services are rendered. The Faculty Practice will be happy to provide the patient with an itemized statement that can be submitted to the patient's insurance carrier by the patient.

*The Faculty Practice is a contracted Premier Provider for those on the USC Delta Dental PPO plan; for all others, the Faculty Practice is a contracted Delta Dental PPO provider, except for Prosthodontic (general/restorative dentistry) services, for which the Faculty Practice is an out-of-network provider. As an out-of-network provider, the patient cost for these services will be higher. It is the patient's responsibility to check eligibility for coverage and associated costs. The Faculty Practice does not accept Delta Dental DMO or any other PPO/DMO insurance.

Print Name

Signature

Date

Herman Ostrow School of Dentistry of USC

Faculty Practice

APPLICATION FOR TREATMENT Chart # ______

Patient Information (To be completed by the patient – Please PRINT in ink)

Last Name: ______ Date: ____ / ____ / ____

First Name: ______ Middle Name: ______

Home Address: ______

City: ______ State: ______ Zip Code: ______

Home Phone: ( ) ______ Work Phone: ( ) ______

Cell Phone: ( ) ______

Email address: ______

Driver's License: ______

California ID: ______ ☐ Other ______

Passport: ______

Employer: ______

Sex: ☐ Male ☐ Female ☐ Other

Birth date: ______

Primary Language(s) Spoken: ______

Ethnicity: (please select)
☐ Asian ☐ Caucasian
☐ Hispanic ☐ Other
☐ African American
☐ American Indian/Alaskan native
☐ Pacific Islander
☐ Unknown

Are you associated with USC? ☐ Yes ☐ No If so, how? ______

Emergency Contact: ______ Relationship: ______

Emergency Contact Phone :( ) ______

Major dental problem/reason for coming to USC School of Dentistry: ______

Last Dentist: ______ Phone: ( ) ______

Address: ______ City: ______ State: ______ Zip: ______

Current Medical Doctor: ______ Phone:( ) ______

Address: ______ City: ______ State: ______ Zip: ______

Insurance/Financial Information (To be completed by the patient – Please PRINT in ink)

Previously a patient here? ☐ Yes ☐ No Year ___ Insurance: ☐ Delta ☐ Delta/USC ☐ Denti-Cal ☐ Other

Carrier Name: ______

Subscriber: ______ Subs. Birthdate: ______

Relationship: ______ Plan #: ______ Group #: ______

Person Responsible for Payment: ______ Phone: ______

Please be aware that your dental insurance may not pay for the total amount of your treatment and you may be responsible for any co-pays or amount that your insurance company does not cover. Your completion of this form is your agreement to this responsibility.

Revised FP 05222014

Ostrow School of Dentistry of USC

Faculty Practice

The Herman Ostrow School of Dentistry
Patient Understanding and Informed Consent

General Information: The Ostrow School of Dentistry will be referred to as the "School" in this document. The Faculty Practice is the School's faculty practice. Patients will receive dental care here by faculty dentists and staff hygienists of The School. The School reserves the right to deny acceptance of patients into our dental treatment programs.

Emergency Care:

If an emergency or postoperative complication arises after hours or on a weekend or holiday, please call 213 740-2012 and a doctor on call will be contacted to assist you.

Consent to Dental Procedures: Before you receive treatment, you are encouraged to ask your faculty dentists and staff hygienists of The School about the procedures he/she recommends for you. Ask any questions you might have before you decide to give your consent for treatment. All dental procedures may involve risks or unsuccessful results and complications, and no guarantees are made regarding any result or cure. You, as our patient, have the right to be informed of any such risks and potential consequences of not performing treatment, the nature of the procedure, expected benefits, and availability of alternative methods of treatment. You have the right to consent to or refuse any proposed procedure at any time prior to its performance. The School also reserves the right to not perform specific treatment requested by a patient.

Health: If you have any changes in your health status or changes in your medicines, you will inform your dental provider. If you are taking a type of drug called bisphosphonate (i.e. Fosamax®, Actonel®, Boniva®, Skelid®, Didronel®, Aredia®, Zometa® and Bonefos®), you may be at risk of developing osteonecrosis (bone death) of the jaw and certain dental treatment may increase that risk.

X-rays: Dental x-rays will be taken as necessary and appropriate for examinations, diagnoses, consultations, and treatments.

Photographs: Patient photographs may be taken to document a clinical condition, to record examination findings, and/or for teaching purposes.

Patient's Financial Responsibility: Patients who receive treatment at the Practice will be charged for treatment based on the Practice's current fee schedule. A fee estimate will be provided before beginning treatment. Payment for services is due when treatment is rendered. As a courtesy, the Practice will bill Delta Dental for Delta Dental patients covered by USC's Delta Dental plan. Any co-pays, co-insurance, or over the benefits limit fees due are the responsibility of the patient or guarantor at the time service is rendered. Patients must also provide personal identification that may include their social security numbers to process dental insurance claims and/or to request patient record information.

Keeping Your Appointments: You are required to be on time for your appointments. If you find that you are unable to keep an appointment, you agree to notify the Practice *at least* 24 business hours in advance. Appointments cancelled without at least 24 business hours' notice may result in a "Missed Appointment" fee.

Discontinuance of Treatment: The Faculty Practice reserves the right to discontinue your dental treatment. Should your treatment be stopped, any remaining credit balance for services not yet provided will be refunded to you.

Grievances: Please discuss any grievances with the Faculty Practice's Office Manager or Senior Clinical Administrator. Both may be reached by calling 213-740-2012 or via email at dentists@usc.edu. If you have

concerns that your doctor or Practice management cannot resolve, please contact our Patient Advocate at the Ostrow School of Dentistry of USC, Office of Clinical Affairs at telephone number 213-740-1774 or via email: patientfeedback@usc.edu.

Security: You understand that for security purposes cameras are present throughout the School.

Release: You hereby agree to release, hold harmless and waive all claims, losses, or damages resulting or relating to the treatment rendered hereunder by the student doctor, resident, student dental hygienist, faculty or School.

Release: You hereby agree to release, hold harmless and waive all claims, losses, or damages resulting or relating to the treatment rendered hereunder by the student doctor, resident, student dental hygienist, faculty or the School. The undersigned certifies that he/she has read and is willing to comply with the foregoing, and is the patient, *the parent or guardian of the patient with authority to give consent,* or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms. In addition, you acknowledge that you received a copy of the School's PATIENT BILL OF RIGHTS AND RESPONSIBILITIES.

Patient: ______________________________

Witness (Faculty): ______________________________ Date: ____________________

Parent/Guardian: ______________________________

Herman Ostrow School of Dentistry of USC Faculty Practice

Medical History Questionnaire

Patient Name: ______________________________Date of Birth: _______________

Reason for visiting the USC Faculty Practice:____________________________________

Please answer all questions **by checking a box under YES or NO**.
Your responses will be held strictly confidential and will only be used to help assess your medical condition. If you have any hesitations, please express your concern to a member of our team.

Do you have, or did you ever have, any of the following?
Cardiovascular:

YES NO
[ ] [ ] High blood pressure
[ ] [ ] Heart disease from childhood
[ ] [ ] Heart murmur
[ ] [ ] Rheumatic fever
[ ] [ ] Use of Phen-Fen
[ ] [ ] Pacemaker
[ ] [ ] Vascular graft
[ ] [ ] Heart valve replacement
[ ] [ ] Heart attack
[ ] [ ] Heart surgery
[ ] [ ] Congestive heart failure
[ ] [ ] Angina (chest pain)
[ ] [ ] Irregular heart beat
[ ] [ ] Stroke
[ ] [ ] Increased cholesterol

Endocrine/Hematologic/ Oncologic/Immune:

YES NO
☐ ☐ Frequent hunger
☐ ☐ Frequent thirst
☐ ☐ Diabetes
☐ ☐ Thyroid disease
☐ ☐ Hemophilia
☐ ☐ Sickle cell disease
☐ ☐ Bleeding tendency
☐ ☐ Anemia
☐ ☐ Cancer
☐ ☐ Radiation therapy
☐ ☐ Chemotherapy
☐ ☐ HIV infection/AIDS
☐ ☐ Organ transplant
☐ ☐ Blood transfusion

Do you have, or did you ever have, any of the following? Musculo-Skeletal/CNS/Developmental:

YES NO
☐ ☐ Chronic jaw and facial pain
☐ ☐ Chronic headache pain
☐ ☐ Chronic neck pain
☐ ☐ Popping or clicking in your jaw
☐ ☐ Joint replacement
☐ ☐ Osteoarthritis
☐ ☐ Rheumatoid arthritis
☐ ☐ Spinal cord injury
☐ ☐ Seizures
☐ ☐ Dizziness
☐ ☐ Weakness
☐ ☐ Multiple Sclerosis
☐ ☐ Cerebral palsy
☐ ☐ Intellectual Disability
☐ ☐ Dementia / Alzheimer's
☐ ☐ Fainting spells
☐ ☐ Visual impairment
☐ ☐ Glaucoma
☐ ☐ Hearing impairment

Gastro-Intestinal/Genito-Urinary:

YES NO
☐ ☐ Hepatitis (A, B, C, or other?)
☐ ☐ Kidney dialysis
☐ ☐ Ulcers
☐ ☐ Sexually transmitted disease
☐ ☐ Denied permission to give blood

Psychological:

YES NO
☐ ☐ Anxiety / Nervousness
☐ ☐ Depression
☐ ☐ Mental health treatment
☐ ☐ Insomnia

Respiratory:

YES NO

- ☐ ☐ Asthma
- ☐ ☐ Chronic Sinus Problems
- ☐ ☐ Night sweats
- ☐ ☐ Emphysema
- ☐ ☐ Tuberculosis

Other: ______________________

Social:

YES NO

- ☐ ☐ Do you use tobacco products? If so, how much? ____________
- ☐ ☐ Do you drink alcohol?
- ☐ ☐ Every day? If so, how much? ____________
- ☐ ☐ Do you use recreational drugs?

Medication Allergy or Intolerance:

YES NO

- ☐ ☐ Penicillin
- ☐ ☐ Dental anesthetic ("Novocain")
- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Latex products
- ☐ ☐ Iodine

Other: __________________

____

Do you have any medical conditions not already mentioned?

____

____

History of Hospitalization/Surgical Procedures:

____

Family: Did a parent, sibling or child of yours have any of the following?

YES NO

- ☐ ☐ Diabetes
- ☐ ☐ High blood pressure
- ☐ ☐ Heart disease
- ☐ ☐ Bleeding tendency
- ☐ ☐ Cancer

Medications:

YES NO

☐ ☐ Are you taking any prescription medicines, any over-the-counter items, or any herbal medicines now? If so, please list them and the doses you use:

____

____

____

____

____

Do you or have you used bisphosphonate medication (i.e. Fosamax®, Actonel®, Boniva®, Skelid®, Didronel®, Aredia®, Zometa® and Bonefos®) to prevent or treat osteoporosis or as part of a cancer treatment?

YES NO

☐ ☐

(*If "**yes,**" please ask for an informational page about bisphosphonate medications --- oral and/or intravenous*)

Other:

YES NO

- ☐ ☐ Does the amount of saliva in your mouth seem to be too little?
- ☐ ☐ Does your mouth feel dry when eating a meal?

FEMALES ONLY:

YES NO

- ☐ ☐ Are you pregnant now? If so, #_____months
- ☐ ☐ Do you take birth control pills?
- ☐ ☐ Are you breast feeding now?

To the best of my knowledge, all of the preceding answers are true. If I have any change in my health status, or any change in my medicines, I will inform my dental health care provider at my next appointment.

______________________________ ______________________________

Patient Signature (or parent/guardian for patients under 18) **Date**

____

Dental Practitioner: PRINT name, date, and add signature.

1206D-1025

USC PATIENT E-MAIL CONSENT FORM
To address the risks of using e-mail
If you choose to communicate with your Provider by e-mail you must review and consent to the conditions or instructions set forth below.

Email Address: ______________________________

1. RISK OF USING E-MAIL

Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks.

a. E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to intended and unintended recipients.
b. E-mail senders can easily misaddress an e-mail.
c. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
d. Employers and online services have the right to archive and inspect e-mail transmitted through their systems.
e. E-mail can be intercepted, alerted, forwarded, or used without authorization or detection.
    1. Understand that the content of the e-mail may be monitored by USC to ensure appropriate use.
f. E-mail can be used to introduce viruses into computer systems.
g. E-mail can be used as evidence in court.
h. E-mails may not be secure, including at USC, and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. CONDITIONS FOR THE USE OF E-MAIL

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of e-mail information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a. **Although Provider will endeavor to read and respond promptly to an e-mail from the patient, Provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time sensitive matters.**
b. E-mail must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via e-mail.
c. **All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.**
d. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling.
e. Provider will not forward patient identifiable e-mails outside of USC healthcare providers without the patient's prior written consent, except as authorized or required by law.
f. The patient should not use e-mail for communication regarding sensitive medical information. According to California law, your provider may not communicate any lab results unless your e-mail correspondence is conducted through a secure server. Additionally, e-mail must never be used for results of testing related to HIV, sexually transmitted disease, hepatitis, drug abuse or presence of malignancy, or for alcohol abuse or mental health issues.
g. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
h. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:

a. Avoid use of his/her employer's computer.
b. Put the patient's name in the body of the e-mail. In the body of the message, include your name and your identification number (Medical Record Number) or your date of birth.
c. Key in the topic (e.g., medical question, billing question) in the subject line.
d. Inform Provider of changes in his/her e-mail address.
e. Acknowledge any e-mail received from the Provider.
f. Take precautions to preserve the confidentiality of the e-mail.

4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by e-mail. If I have any questions I may inquire with my treating physician or the USC Privacy Officer.

Patient Signature: ______________________ Date: __________ Time: __________

Witness Signature: ______________________ Date: __________ Time: __________

PATIENT E-MAIL CONSENT FORM

PATIENT ID

1206D-1025 (10-11)

Patient Bill of Rights and Responsibilities

The Herman Ostrow School of Dentistry of USC and its Affiliated Practices strives to provide a high quality of care and service to our patients. As a valued patient you have the following rights and responsibilities:

- ***You have a right*** to an appointment with your healthcare provider in a timely manner.
- ***You have a right*** to considerate, respectful, and confidential treatment.
- ***You have a right*** to have complete and current information about your condition.
- ***You have a right*** to know in advance the type and expected cost of treatment.
- ***You have a right*** to expect healthcare providers to use appropriate infection and sterilization controls.
- ***You have a right*** to an explanation of the prescribed treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment, and expected outcomes of these treatments, and be told, in language you can understand, the advantages and disadvantages of each.
- ***You have a right*** to ask your healthcare provider to explain all the treatment options regardless of your insurance benefit coverage or cost.

- ***You have a responsibility*** to keep your appointment, or reschedule in a timely manner.
- ***You have a responsibility*** to be considerate and respectful to others like your healthcare members and other patients.
- ***You have a responsibility*** to provide complete and current information about your condition.
- ***You have a responsibility*** to participate in your care and keep current on your cost of treatment and insurance coverage, if any.
- ***You have a responsibility*** to dress and present yourself appropriately.
- ***You have a responsibility***, as well as you are able, to participate in prescribed treatment, carefully weigh the consequences of accepting or refusing treatment, and appropriately discuss changes that might occur during your course of care.
- ***You have a responsibility*** to make reasonable decisions within yours and the school's limitations.

KEEP FOR YOUR RECORDS