Dental Clinic

Dear Client:

Welcome to the Bering Omega Dental Clinic. Dental Clinic services are reserved exclusively for individuals with HIV/AIDS. Our mission is to improve the quality of life for those with critical needs by providing physical, emotional, and spiritual assistance to the patients who receive our care. Part of the goal of the Dental Clinic is to create a safe and pleasant environment in which you, our patient, receive your dental care. Your privacy will be protected.

Becoming A Patient

The following will explain the steps to become a patient at Bering Dental Clinic, how to make your first appointment, how appointments are scheduled, and other information you will need to know.

If you live in the following counties**,** ***you*** must register at a **CPCDMS registration agency** ***prior*** to your intake at the Dental Clinic. These counties are: **Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller.** Information on CPCDMS registration sites is attached (page 6).

Intake Days: *PLEASE REFER TO THE ATTACHED INFORMATION ON INTAKE DAYS (page 3)*. On these days, you will be seen in the ***order you sign in*** with a ***completed application*** on a ***first come, first serve basis.***

You will need to bring your completed registration packet along with the following documents and PROOF OF REGISTERING WITH CPCDMS if you live in one of the above-mentioned counties:

1. **Complete Blood Count (CBC).** Blood work ***must*** have been done within the past 6 months. CBC ***must always*** be within 6 months of collection date to be current for our services.

2. **Doctor Statement**. You must show proof of an HIV or AIDS diagnosis. *This is separate from the CBC* and can be either a Western Blot test of a statement of treatment by your physician. They can also circle a diagnosis on the form we've provided at the end of this packet.

3. **Proof of Identity**. Texas I.D. card, Texas Driver's License, school or state I.D. I.D. **MUST** have picture.

4. **Proof of Residency**. If registered in CPCDMS, that is all a client will need for proof of residency. If you live in a non-CPCDMS county, proof of residency can be electric, phone, or cable bill in patient's name at local address. Other acceptable documents include a lease in patient's name, government letter (SSI/SSD) addressed to patient, or letter from case manager or agency stating you live at your address. Texas I.D. and Driver's License can **NOT** be used for Proof of Residency.

5. **Proof of Income**. Again, if registered in CPCDMS, that is the only proof of income a patient will need. If a client lives in a non-CPCDMS county, proof of income can include a current award letter, recent check stub, letter of support, or three consecutive recent bank account statements if living on savings.

These documents ***must*** be updated ***by you*** every calendar year. After these items are completed, your first appointment will be made for an examination and x-rays.

No dental work will be done on your intake visit.

Please make sure that you complete (In blue or black ink) all of the attached forms ***prior*** to your intake. Be sure to sign and date everything. All ***incomplete forms*** will be ***returned to you***, and this will only delay your registration for dental services.

Please ***do not mail or fax*** your competed application. Make sure that you have it with you on the day of your intake.

- **PLEASE NOTE THAT FAXED APPLICATIONS ARE NOT ACCEPTED**
- **ALL APPLICATIONS LEFT AFTER 6 MONTHS WILL BE SHREDDED**

Bering Omega Community Services - Dental Clinic
1427 Hawthorne Street
Houston, Texas 77006
Phone: 713-341-3791
Fax: 713-524-7995

INTAKES FOR NEW PATIENTS

Intake days for new dental clinic patients are Mondays and Fridays only. The Intake Coordinator is available from 9:00 a.m. to 1:00 p.m. Please arrive early as the intake coordinator may leave before 1 p.m. ***You do not need an appointment***.

Please have your ***completed application*** as well as all the required documentation when you arrive for intake.

Intakes will be seen in the order you sign in *with your completed paperwork.*

At the time of your intake, your chart will be put together, policies explained to you, and your first appointment will be scheduled.

YOU WILL NOT SEE A DENTIST AT INTAKE.

Your first appointment will be for an exam and x-rays only. *No work will be done on this visit*. The doctor will lay out your treatment plan and we will schedule your next appointment for any treatment that needs to be done.

ATTENTION CLIENTS

Bering Omega Community Services is proud to have been providing outstanding oral health care without charge to our valued clients since 1987.

Health Resources and Services Administration (HRSA) is now enforcing the collection of co-payments or sliding scale fee collections from clients above 100% of the federal poverty income level.

Bering Omega Community Services will begin charging a $20 co-payment for each dental clinic visit for all clients above 100% of the federal poverty income level.

We appreciate your understanding and cooperation which will help us continue to offer the highest quality care to as many clients as possible.

Bering Omega
Community Services

Appointment Policy

Regularly Scheduled

Regular appointments are scheduled for a specific time with a dentist. We ask that you are at least 15 minutes early. If your chart is not set up in the back for the dentist at your scheduled appointment time, you may not be seen. If you need to cancel or reschedule, you must call at least **24 hours in advance from your appointment time and speak directly to a front desk person**. If you violate the appointment policy twice within six months (late, no 24-hour notice) you will be ineligible for regular appointments and will be scheduled for standby appointments.

Standby

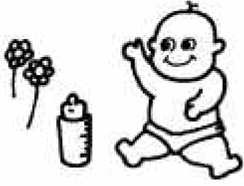
Standby appointments are scheduled first thing in the morning or afternoon and patients are worked into the schedule as best possible. *You may wait several hours to be seen* and your patience is greatly appreciated. If we are overbooked and need to reschedule your appointment, you will be given another standby appointment.

Removal From Standby

In order to be removed from standby appointments and be eligible to receive regularly scheduled appointments again, you must be ON TIME for two consecutive standby appointments, or after six months, whichever comes first.

Please only cancel or reschedule when absolutely necessary, as any disruptions to our scheduling will necessitate returning completely to the standby appointment policy.

FREE CHILDCARE



Do you have children that need to be supervised while you are visiting the Dental Clinic or Care Center? *Please note: children under 12 cannot be left unsupervised in the waiting area.*

AIDS Foundation Houston (AFH) has set up a volunteer child monitoring service. Unfortunately, the hours are only available on THURSDAYS from 8:00 AM – 5:00 PM. This service is FREE and only available to clients of Bering Omega Dental Clinic and The Care Center.

You MUST REGISTER with them one time BEFORE they will be able to watch your children. **After you register, you MUST set up appointments with AFH**.

To qualify, the following documents are required:

- Proof of HIV status (child or caregiver)
- Proof of residency
- Proof of income
- Valid Identification

PLEASE NOTE: YOU MUST CONTACT THE SITTERS 24 HOURS PRIOR TO YOUR APPOINTMENT TO RESERVE A SPACE FOR YOUR CHILD.

For Further Information call
713-873-4162

Bering Omega
Community Services

DENTAL CLINIC

Dear Client,

In order to comply with our funding sources, our patients must register with the new CPCDMS computer system. This system will allow you to show your **proof of income** and **proof of residency** once per year at a registration site, and then all the associated agencies can access this system. You will only have to show these documents to one agency, and will not have to carry them to each agency as you have done in the past. If you are not registered, we will be unable to see you.

If you live in the following counties, you must register at a CPCDMS registration agency. **These counties are: Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller. Information on CPCDMS registration sites is below.**

CPCDMS registration sites and contacts:

AGENCY	CONTACT	PHONE #
AIDS Foundation Houston, Inc.	Bob Taylor	(713) 623-6796
Baylor College of Medicine	Kristin Close	(832) 822-1366
Bering Omega - Hospice Care	Sandy Stacy	(713)341-3781
City of Houston	Sherifat Akorede	(713) 715-8548 cell
Family Services of Greater Houston*	Patrick Richoux	(713) 868-4466
Fort Bend Family Health Center	Sylvia Teeple	(281) 342-0529 x138
Harris County Hospital District	Gail Green	(713) 873-4188
Harris County Sheriff's Office (Jail)	Sam Lopez	(713) 755- 8962
Houston Area Community Services	Ernesto Macias	(713) 426-0027
Legacy Community Health Services	Catherine Yaple	(713) 830-3032
Montrose Counseling Center	Peggie Utecht	(713) 529-0037 x360
St. Hope Foundation	Timika Sam	(713) 778-1300
UT Health Science Center	Kecia Graham	(713) 500-6443
Veteran's Administration	Belinda Rainer	(713) 791-1414 x5292

This system is designed to make obtaining services from different agencies easier for the clients. Please call one of the registration agencies above to schedule an appointment for your registration, prior to your intake at the Dental Clinic.

If you need further assistance or have questions please feel free to call a contact person at a registration site, or ask a dental clinic front desk staff member.

Please note that you will still need to provide **proof of identity and proof of diagnosis** to us **ONCE**. It is also mandatory that you provide us with **a Complete Blood Count (CBC)** every 6 months from the date of the blood work.

Thank you for your cooperation.

BeringOmega Community Services

CONFIDENTIAL HEALTH HISTORY
(Please Print)

Patient's Last Name: ____________________ First: ____________________ Middle Initial: __________

Street Address: ___________________________________ City, State _____________________________

Zip: ________ County: ____________________ Home #: _______________ Other#: ______________

Date of Birth: __________________ Social Security # ___________________________________

Sexual Orientation: _____ Heterosexual (straight) _____ Homosexual (gay) _____ Bisexual

EMERGENCY CONTACT:

Name: _____________________ Phone #: _______________ Relationship: ______________

If you are completing this form for another person, what is your name and relationship to the patient?

______________________________________ ___________________________

Name Relationship

PRIMARY HIV PHYSICIAN NAME: ____

CLINIC: ____ Phone #: ______________________

DENTAL HISTORY:

Please describe any immediate dental problems, including aches, pains, redness, swelling, sensitivity:

____

____

When was your last cleaning? _________________Last dental X-Rays?_____________________

Have you had any problems with dental treatment in the past? YES NO
(if YES, please describe):

____

____

Signature: _________________________________ Date: ________________________

Bering Omega
Community Services

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Question	Yes	No	
Are you under a physician's care now?	O Yes	O No	If yes, please explain: ______
Have you been hospitalized or had a major operation?	O Yes	O No	If yes, please explain: ______
Have you ever had a serious head or neck injury?	O Yes	O No	If yes, please explain: ______
Are you taking any medications, pills or drugs?	O Yes	O No	If yes, please explain: ______
Do you take, or have you taken, Phen-Fen or Redux?	O Yes	O No	______
Have you ever taken Fosamx, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes	O No	______
Are you on a special diet?	O Yes	O No	______
Do you use tobacco?	O Yes	O No	______
Do you use controlled substances?	O Yes	O No	

Women: Are you
Pregnant/Trying to get pregnant? O Yes O No   Taking oral contraceptives? O Yes O No   Nursing? O Yes O No

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐Other If yes, please explain: ______

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Radiation Treatments	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Recent Weight Loss Renal	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Dialysis	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Rheumatic Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	High Cholesterol	O Yes O No	Scarlet Fever	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hives or Rash	O Yes O No	Shingles	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O No
Asthma	O Yes O No	Fainting Spell/Dizziness	O Yes O No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Leukemia	O Yes O No	Stomach/ Intestinal Disease	O Yes O No
Breathing Problem	O Yes O No	Frequent Headaches	O Yes O No	Liver Disease	O Yes O No	Stroke	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tonsillitis	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Osteoporosis	O Yes O No	Tuberculosis	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pace Maker	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
						Yellow Jaundice	O Yes O No

Have you ever had any serious illness not listed above? O Yes O No If yes, please explain: ______

Comments: ______

______

______

______

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN ______ DATE ______

SIGNATURE OF DENTIST ______ DATE ______

Please mark any HIV medications you currently take:

- O **3TC** (Lamivudine, Epivir)
- O **Abacavir** (Ziagen)
- O **Amprenavir** (Agenerase)
- O **Atazanavir** (Reyataz)
- O **Atripla** (Efavirenz/Tenofovir/FTC)
- O **AZT** (Zidovudine, Retrovir)
- O **Combivir** (AZT/3TC)
- O **d4T** (Stavudine, Zerit)
- O **Darunavir** (TMC114, Prezista)
- O **ddC** (Zalcitabine, Hivid)
- O **ddI** (Didanosine, Videx)
- O **Delavirdine** (Rescriptor)
- O **Efavirenz** (Sustiva, Stocrin)
- O **Epzicom** (Abacavir/3TC, Kivexa)
- O **Fosamprenavir** (Lexiva, Telzir)
- O **FTC** (Emtricitabine, Emtriva)
- O **Indinavir** (Crixivan)
- O **Isentress** (Raltegravir, MK-0518)
- O **Kaletra** (Lopinavir/Ritonavir)
- O **Nelfinavir** (Viracept)
- O **Nevirapine** (Viramune)
- O **Ritonavir** (Norvir)
- O **Saquinavir** (Fortovase, Invirase)
- O **T-20** (Enfuvirtide, Fuzeon)
- O **Tenofovir** (Viread)
- O **Tipranavir** (Aptivus)
- O **Trizivir** (AZT/3TC/Abacavir)
- O **Truvada** (Tenofovir/FTC)

Do you take any medications for high blood pressure or diabetes? O **Yes** O **No**

If yes, which medications? ____

____

Please list any other medications you take: ____

____

____

Patient Initials: ___________ **Dentist's Signature:** ____

INTAKE ASSESSMENT FORM

PLEASE *PRINT* THE ANSWERS TO THE FOLLOWING QUESTIONS:

Date: _______________ DOB: ______________ Social Security #: _________________________

Last Name: _______________________ First: ___________________ Middle: _______________

Mother's Maiden Name: ________________________________

REFERRAL SOURCE

_____ Physician/Clinic: _________________
_____ Case Manager: _________________
_____ Friend
_____ Home Health/Social Worker
_____ Other Service Agency

HIV INFECTION CATEGORY

_____ Homosexual/Bisexual contact
_____ Homosexual/Bisexual contact & IV drug use
_____ Heterosexual contact only
_____ Heterosexual contact & IV drug use
_____ Transfusion/blood products/tissue recipient
_____ Other/undetermined

HIV STATUS

_____ HIV+ with related illness
_____ HIV+ with no related illness
_____ AIDS Diagnosis

DIAGNOSIS DATE: ____________

GENDER

_____ Male
_____ Female

MARTIAL STATUS

_____ Divorced
_____ Married
_____ Never Married
_____ Separated
_____ Widowed

Do you have Medicaid?

No _____ Yes ____

Do you have Medicare?

No _____ Yes ____

RACE

_____ African American (AA)
_____ Asian
_____ Native American (NA)
_____ White
_____ Pacific Islander
_____ Multi – AA/White
_____ Multi – Asian/White
_____ Multi – NA/AA
_____ Multi – NA/White
_____ Other Multi-Racial
_____ Other: _____________________

Hispanic Origin? _____ Yes _____ No

PRIMARY LANGUAGE

_____ English
_____ Spanish
_____ American Sign Language
_____ Other: __________________

EDUCATION

_____ Bachelors
_____ Graduate/Masters
_____ High School Grad/GED
_____ Non-High School Grad
_____ Some College

RELIGION (optional)

_____ Buddhist
_____ Catholic
_____ Protestant
_____ Jewish
_____ Muslim
_____ None

Who is your current Dental Insurance Provider?

____

CONSENT FOR THE RELEASE/EXCHANGE OF INFORMATION

I, ______________________________, _______________, authorize personnel of Bering Omega Community Services,
Print Client's Name — Date of Birth

to exchange information with the agencies and/or individuals identified below for the purpose of coordination of care.

Your medical/dental information, including clinical photographs, may be used for research and/or publication purposes. We may also contact you by mail, email, or telephone communications regarding your treatment or services obtained here.

This consent may be revoked in writing by the undersigned at any time except to the extent that action may already have been taken on it.

A photocopy of this form shall be considered as effective and valid as the original.

NAME / ENTITY	RELATIONSHIP	PHONE NUMBER
	Clinic	
	Primary HIV Physician	
	Emergency Contact	

I UNDERSTAND THAT THIS CONSENT SHALL EXPIRE TWO YEARS FROM DATE SIGNED AND I UNDERSTAND ITS MEANING. ALL THE BLANKS WERE FILLED IN BEFORE THE FORM WAS SIGNED BY ME.

____ ____________________
Client Signature or mark (if of legal age and legally competent) — date

____ ____________________
Parent/Guardian/Power of Attorney — date

____
Printed Name of Witness/ **Bering Omega Staff Signature**

____ ____________________
Signature of Witness/ **Bering Omega Staff Signature** — date

CENTRALIZED PATIENT CARE DATA MANAGEMENT SYSTEM

CONSENT FOR SERVICES

Client 11-Character Code										

I, ____, wish to receive services provided by

Bering Omega Community Services, an agency linked to the ***Centralized Patient Care Data Management System*** (***CPCDMS***), a patient/client services computer database maintained by Harris County Public Health & Environmental Services – HIV Services.

I understand that key activities include assessing my eligibility and needs; providing me with requested services; and ensuring the coordination, monitoring and quality of services received.

I understand that no confidential information pertaining to me will be entered into CPCDMS. I understand that no information or records associated with my case will be knowingly released to anyone or any agency without my informed written consent, or a subpoena, court order or legal statute. Furthermore, I understand that an additional consent for the release/exchange of information to verify my eligibility before I can receive Ryan White I funded services.

By my signature below, I give permission for de-identified information pertaining to my demographics and services to be entered into the ***CPCDMS*** central site. The centralized database can be accessed by authorized personnel to assess the system's provision of services for planning, program development, statistical reporting and research purposes. **No identifying information, such as my name, address or social security number will be stored at the central site.**

I am giving this consent of my own free will. This consent will remain in effect until I provide a written statement revoking my consent.

I fully release and hold the entity(ies) administering the funding for these services; Harris County Public Health & Environmental Services, the entity responsible for overseeing and maintaining the ***CPCDMS***;

Bering Omega Community Services ; their Officers, Directors, Board Members, employees and agents (i.e.: volunteers, AGENCY NAMED ABOVE, students) harmless from any and all damages, losses, liabilities (joint or several), payments, obligations, penalties, claims, litigation, demands, defenses, judgments, suits, proceedings, costs, disbursements or expenses (including without limitation, fees, disbursements and expenses of attorneys, and other professional advisors and of expert witnesses and costs of investigation and preparation) of any kind or nature whatsoever resulting from, relating to or arising out of my receipt of services.

I was given a copy of my client rights and I was offered an opportunity to discuss them in a language and format I understand.

____ ____________________

CLIENT SIGNATURE OR MARK (IF OF LEGAL AGE AND LEGALLY COMPETENT) DATE

____ ____________________

PARENT/GUARDIAN/POWER OF ATTORNEY (WITH COPY OF AUTHORITY ATTACHED) DATE

CONSENT TO VERIFY ELIGIBILITY FOR SERVICES

Client 11-Character Code										

I, ____, ______________________________,
Client Name Date of Birth

hereby authorize Bering Omega Community Services to access **the *Centralized Patient Care Data Management System*** **(CPCDMS)** to verify my registration at any agency currently linked to the CPCDMS, maintained by Harris County Public Health & Environmental Services, HIV Services.

The purpose of this release/exchange is to verify my eligibility for Ryan White I funded services provided by this agency and is limited to the following specific information:

- My registration date and client status
- The name of the agency maintaining my client record
- My eligibility expiration date
- My HIV/AIDS status
- My zip code and county of residence
- My financial eligibility level (based on my income)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, 42 CFR, Part 2, Section 33 of Public Law 91-6161 as amended by Public Law 93-282; Texas Health & Safety Code, Chapter 81, Section 81.050 and all applicable state and local laws, rules and regulations; and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I am authorizing this release/exchange of information of my own free will and with informed consent. I may revoke this consent in writing at any time, except to the extent that action may already have been taken in reliance on it.

Further, I understand that this consent shall expire and must be re-obtained two years after the document is signed/dated below.

A photographic copy of this authorization shall be considered as effective and valid as the original.

______________________________________ ______________________________
Client Signature of Mark (if of legal age and legally competent) Date

______________________________________ ______________________________
Patient/Guardian/Power of Attorney Date

CLIENT APPEALS/GRIEVANCE PROCEDURES

Bering Omega Community Services desires to foster the prompt and orderly consideration and resolution of client questions, complaints, conflicts, etc.

For the purposes of this document, "client" refers to any individual receiving services through Bering Omega programs.

PROCEDURE

The following process is designed to resolve all client questions, complaints, conflicts, etc. that may arise during the client/Bering Omega relationship in a fair and efficient manner.

1. Initial Discussion:
   Where the questions, complaints, conflicts, etc. are not resolved after initial discussions, the client should address their issues to the **Program Manager or Program Director**. Program Managers should listen to the questions, complaints, conflicts, etc. and resolve such issues as best as they can, communicating their decisions to the clients in a timely manner.

2. Vice President of Operations Mediation and Response: If clients are dissatisfied after their initial discussions with a Program Manager, the client should next address their issues to the **Vice President of Operations**. The Vice President of Operations should investigate the situations, discuss the issues with the client, and respond to the client within one (1) week after the discussion.

3. President Review: If clients are dissatisfied with the response of the Vice President of Operations, the client should next address their issues **in writing** to the **President**. The President is expected to review the situations, make a decision, and contact the client within two (2) weeks of the review to discuss the decision. The decision of the President will be considered final and will end the internal review of the clients' issues.

4. If any issues concern the President, and if any clients are dissatisfied after their initial discussions with the President, the client should address their issues, **in writing**, to the **Chair of the Board of Trustees**. The Chair should investigate the situations and respond with his/her decision, in writing, to the client within thirty (30) days of the investigation. The decision of the Chair will be considered final and will end the Bering Omega review of the clients' issues.

I. EXTERNAL DUE PROCESS

Should the client be dissatisfied with the decision of Bering Omega Community Services regarding the grievance/complaint, the client has the right to pursue an external due process.

ANY CLIENT HAS A RIGHT TO FILE A COMPLAINT WITH THE TEXAS DEPARTMENT OF HUMAN SERVICES (512) 834-6788, P.O. BOX 149030, AUSTIN, TEXAS 78714-9030; HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, 500 LOVETT BLVD, SUITE 100, HOUSTON, TEXAS 77006, (713) 526-1016; OR HOUSTON/HARRIS COUNTY (RYAN WHITE) PLANNING COUNCIL, 2223 WEST LOOP SOUTH, SUITE 417, HOUSTON, TEXAS 77027, (713) 439-6090.

IN THE OPERATION OF THE SPECIAL NUTRITION PROGRAMS, PARTICIPANTS ARE NOT DISCRIMINATED AGAINST BECAUSE OF RACE, SEX, COLOR, NATIONAL ORIGIN, AGE, POLITICAL BELIEF, RELIGION OR DISABLIITY, IF YOU BELIEVE YOU HAVE BEEN DISCRIMINATED AGAINST, WRITE IMMEDIATELY TO:

Director: Civil Rights Department
701 W. 51st Street (78751)
P.O. Box 149030 (78714-9030)
Mail Code W-106
Austin, Texas

voice – 512-438-3630
TDD – 512-438-4313
Fax – 512-438-4748

And/or you may contact the Secretary of Agriculture, Washington, D.C. 20250

I HAVE READ AND UNDERSTAND THE GRIEVANCE PROCEDURES CONTAINED HEREIN, AND HAVE RECEIVED A COPY OF THIS PROCEDURE.

____________________________________ __________________
CLIENT SIGNATURE DATE

____________________________________ __________________
GUARDIAN SIGNATURE DATE

____________________________________ __________________
BERING OMEGA STAFF SIGNATURE DATE

CLIENT PARTICIPATION FORM

NOTICE, AGREEMENT, RELEASE, INDEMNITY

HOLD HARMLESS AND COVENANT NOT TO SUE

EACH PATIENT OR PARENT/LEGAL GUARDIAN OF THE DENTAL CLINIC IS REQUESTED TO READ AND SIGN THE FOLLOWING:

1. The DENTAL CLINIC is operated and maintained by Bering Omega Community Services. Bering Omega Community Services is a charitable, non-profit corporation with a 501 (C) (3) status.

2. The DENTAL CLINIC is staffed by both employed and volunteer dentists, as well as hygienists and other support personnel.

3. Because of the charitable, non-profit purposes of Bering Omega Community Services, it is necessary to advise each Patient of the LIMITED and PART-TIME nature of the services provided by the DENTAL CLINIC. Also, the DENTAL CLINIC, it's benefactors, and Bering Omega Community Services request that each Patient, or Parent/Legal Guardian sign the following Agreement regarding release, limitation and indemnification of potential liability of the DENTAL CLINIC, its benefactors, and Bering Omega Community Services. to the Patient.

NOTICE OF LIMITED AND PART-TIME SERVICES

4. The DENTAL CLINIC provides only LIMITED and PART-TIME outpatient dental care to individuals suffering from Acquired Immunological Deficiency Syndrome (AIDS), and HIV disease.

5. The DENTAL CLINIC is operated only on certain announced days and hours of each week, subject to the availability of dentists and staff. It is not opened on holidays.

6. The DENTAL CLINIC is not intended or otherwise represented to be "full service." Neither the DENTAL CLINIC (including B.O.C.S>) nor any associated volunteer undertakes, promises, contracts to represent to provide any service other than such LIMITED services which can be performed on-site at the DENTAL CLINIC. Likewise, because the DENTAL CLINIC relies on the services of volunteer dentists, hygienists, and assistants, the DENTAL CLINIC, it's volunteer dentists, staff, and Bering Omega Community Services do not undertake to provide any service at any other time, other than those limited times announced in the DENTAL CLINIC schedule during which the DENTAL CLINIC may be open and can be staffed by at least one licensed part-time volunteer dentist. What this means is the emergency and or extraordinary services cannot and will not be offered or provided. Volunteer dentists have no obligation to a Patient provided professional services at their individual offices, clinics, or institutions, or at any time other than when such individuals are present at the DENTAL CLINIC for purposes of providing volunteer care. The DENTAL CLINIC and B.O.C.S> do not undertake to see, solicit, or otherwise provide the Patient with substitute, off-premises, off-hours, emergency or extraordinary services. Such services remain the sole responsibility of the Patient or Parent/Legal Guardian.

7. Because of the non-profit and charitable status of Bering Omega Community Services. and their dependence upon contributions and volunteers to operate the DENTAL CLINIC, the DENTAL CLINIC is subject to being closed indefinitely at any time without notice. The Patient is offered and receives dental services subject to such contingency.

AGREEMENT OF PATIENT AND OR GUARDIAN

In consideration and receipt by Patient of the LIMITED and PART-TIME services provided by the DENTAL CLINIC, it is acknowledged and agreed by the Patient or Parent/Legal Guardian as follows:

8. The Patient or Parent/Legal Guardian has read the foregoing statements and notices, and is voluntarily signing this Agreement.

9. The fee, if any, paid by or on behalf of the Patient for services represents discounted services at or below cost based upon ability to pay. No profit is derived therefrom.

10. In consideration for the forbearance of profit and other fee reductions, the Patient or Parent/Legal Guardian agrees to INDEMNIFY and HOLD the DENTAL CLINIC HARMLESS from any and all injuries, claims, and damages of every kind, including injury of death, which the Patient may sustain in the course of receiving dental care at or from the DENTAL CLINIC, whether such damages and injuries result in whole or in part form, or are otherwise caused in any way by, the Patient's or Parent/Legal Guardian's own negligence, actions, conduct, or omissions, or the negligence, actions, conduct or omission of any other person or entity, specifically included, but not limited to the following:

10A. The DENTAL CLINIC, The Bering Omega Community Services, any dentist, volunteer dentist, hygienist, benefactor, advisor, consultant, or other support personnel associated with the DENTAL CLINIC in any way, and/or other person or entity donating in whole or in part, or discounting in cost, money, products, services, or labor to the DENTAL CLINIC or Bering Omega Community Services.

11. This Indemnification and Hold Harmless Agreement is meant and intended by all parties to constitute a FULL RELEASE and COVENANT NOT TO SUE by the Patient or Parent/Legal Guardian for any and all damages or injuries sustained, whether such resulting from or caused by, in whole or in part, services rendered, services not rendered, and product or equipment used or not used or conditions of the premises, of or by the person or entities more fully set out in Paragraph 10A above.

12. The Patient or Parent/Legal Guardian assumes all risks for services rendered, and of the premises and location of the DENTAL CLINIC.

13. To the fullest extent allowed by the law, it is understood by all parties that no representations, warranties, or undertaking have been given to the Patient or Parent/Legal Guardian by the persons and entities described in Paragraph 10A, above, whether actual, express or implied. (NOTE: Warranties and or undertakings of which Texas or federal law does not permit waiver or disclaimer are not covered by this paragraph).

14. In applying for and receiving services from the DENTAL CLINIC, the Patient or Parent/Legal Guardian warrants and represents that the Patient has been and is now diagnosed as HIV positive and has been exposed to the AIDS virus, and therefore among other things the client agrees that there shall be no basis for any claim by client or any party acting on behalf of client, that the client has been exposed to the AIDS virus or any opportunistic disease as a result of the services rendered by the DENTAL CLINIC staff or personnel.

15A. The Patient understands that during the course of treatment, it may become necessary to take photographs of the mouth or various parts of the body, and that these photographs may be used for teaching or for publication. The identity of the Patient will be kept confidential. It may also become necessary to take biopsy specimens for diagnosis of disease processes, the information from these biopsies may be used for teaching or for publication.

15. This Agreement does not diminish or limit such immunities and limitations of liability as are otherwise provided by law, including but not limited to Texas Civil Practices and Remedies Code 84.001 et seq.

16. This Agreement is continuing in nature.

17. This Agreement is binding upon the Patient or Parent/Legal Guardian (if any) as well as the Patient heirs, assigns, executors, administrators, personal representatives including "NEXT FRIEND" or any other person or entity claiming by, through, or on behalf of the Patient and or the Patient's estate

18. SEVERABILITY. If any clause, provision, part or subpart (including portions of sentences or paragraphs of the Agreement, or it's application to any person, entity or organization is held to be invalid or otherwise unenforceable, such invalidity and or unenforceability shall not affect other clauses, provisions, parts, subparts, portions of sentences, of paragraphs, or applications of this Agreement that can be given effect without the invalid or unenforceable clause, provision, part, subpart, or portions of sentences or paragraphs.

19. The Patient or Parent/Legal Guardian has read/been read to and understood the foregoing in its entirety, including each part and subpart. The Patient or Parent/Legal Guardian represents that he or she understands the foregoing, and is competent to understand and sign this document. If the Patient is a minor or otherwise not legally competent, the Patient's Parent or Legal Guardian has read and understood the foregoing, and is authorized to sign this document in the Patient's stead.

READ and SIGNED on this _______ day of _______, 20____

Patient's Signature: ______________________________ Patient's Printed Name: ___________________________

If the Patient is a minor or is otherwise legally incompetent, this Agreement must bear the signature of the Patient's Parent or Legal Guardian:

Parent or Legal Guardian:__________________________________

BeringOmega Community Services

APPLICATION FOR HILL-BURTON ASSISTANCE
DENTAL CLINIC

Last Name:	First Name:	M.I.:

EMPLOYMENT
_____ Disabled
_____ Full-Time
_____ Part-Time
_____ Full-time Homemaker
_____ Retired
_____ Self-Employed
_____ Full-Time Student
_____ Unemployed

HOUSING STATUS
_____ Apartment
_____ Homeless
_____ House
_____ Nursing Home
_____ Other

FAMILY SIZE ________

ELIGIBILITY DETERMINATION

NOTICE OF AVAILABILITY OF UNCOMPENSATED SERVICES

To be eligible to receive services, your family income must be at or below the following levels:

Size of Family Unit	Poverty Guideline (300%)
1	$ 32,490
2	$ 43,710
3	$ 54,930
4	$ 66,150
5	$ 77,370
6	$ 88,590
7	$ 99,810
8	$ 111,030

Note: For family units with more than 8 members, add $11,220 for each additional member.

My current monthly income is:
$_______________

My current annual income is:
$_______________

I certify that the above information is true and accurate to the best of my knowledge. If any information I have given proves to be untrue, I understand that the Dental Clinic may re-evaluate my financial status and take whatever action becomes appropriate.

Signature: ________________________________ Date: ______________________

(For Office Use Only)

Type of Income Verification: ____________________________________

Do you receive SSI or SSD? NO YES: ______________________

______ The applicant is approved for care because they are under 300% of the current Poverty Income Guidelines.

Approved By: ________________________________ Date: ______________________

Bering Omega
Community Services

CLIENT ELIGIBILITY FORM

The Dental Clinic is an adult/adolescent dental care facility for persons who are HIV positive. It enrolls clients on a first-come, first-served basis, and need. The dentists at the Dental Clinic are licensed by the Texas State Board of Dental Examiners and is funded through private grants, a subsidy from the Texas Department of Health, Ryan White funding, and private donations. Care is provided without charge to patients.

Criteria for entry into the Dental Clinic program are:

- Person who are HIV infected
- Persons who are minimally dysfunctional and need only minimal assistance in ambulation and nutrition.
- Persons who exhibit behaviors which are NOT HARMFUL to themselves, or to other Dental Clinic patients and/or staff. Persons who demonstrate violence, threats of violence, use of illegal substances, use of alcohol during their visit to the Clinic, abusive language, theft, and/or behavior considered inappropriate , are subject to immediate dismissal.
- Persons who are under the supervision of a physician and who can provide a current physician's statement with indication of HIV status and CBC values, or in emergency situations can provide current CBC values, then proceed to seek physician care before routine dental care is provided.
- Persons who agree to comply with the policies and procedures of the Clinic.
- Persons who are, in the evaluation of the admitting staff worker, sufficiently stable, emotionally, mentally, and physically appropriate for interaction with other patients and staff.

CLIENT BILL OF RIGHTS FOR HIV SERVICES

Each person that is receiving care under the Texas Department of Health (TDH) Services Program has a right to:

- Not be physically or mentally abused or exploited;
- Be treated with respect, consideration, and recognition of his or her dignity and individuality; (The client must also render the same to the provider to receive personal care and treatment in safe, clean surroundings);
- Appropriate care regardless of his/her race, religious practice, color, national origin, sex, age, handicap, marital status, or sexual orientation;
- Communicate in a culturally sensitive manner to address the client's needs for the purpose of getting any type of treatment, care, or services;
- Receive services, care, and treatment regardless of any disability;
- Present grievances to Bering Omega staff, state agencies, or other persons without fear of denial of services; The grievances policy/procedure, as set by the administrative agency must be presented and explained to the client by any service provider; (In the event that this procedure cannot be followed because of direct conflict with the administrative agency or subcontractor, the grievance will be submitted to the consortium);
- Have local confidential records which cannot be released without his/her written permission; (A client may inspect his/her personal records that are maintained by the agency providing the services);
- Have freedom of choice when choosing a provider of comprehensive outpatient health and psychosocial support services;
- Be given the opportunity to actively participate in the planning of his/her service plan or medical treatment.
- Refuse treatment;
- Participate in an annual needs assessment survey.

I HAVE READ, UNDERSTOOD, AND AGREED TO THE CLIENT ELIGIBILITY REQUIREMENTS AND THE CLIENT BILL OF RIGHTS FOR HIV SERVICES.

____ __________________

CLIENT/GUARDIAN SIGNATURE DATE

____ __________________

BERING OMEGA STAFF SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

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

1. **Purpose:** Bering Omega Community Services is committed to providing services designated to meet your needs. We are equally committed to respecting your privacy and protecting the information about you that we may receive. We have prepared this Notice to advise you of what information we collect and how we protect it. Bering Omega Community Services (referred to herein as Bering Omega) and its professional staff, employees, and volunteers follows the privacy practices described in this Notice. We are required by law to maintain the privacy of your health information, whether in paper or electronic records, and to protect the integrity, confidentiality, and availability of your electronic health information when it is collected, maintained, used or transmitted by Bering Omega. However, we must use and disclose your medical information to the extent necessary to provide you with quality health care. To do this, Bering Omega must share your medical information as necessary for treatment, payment and health care operations.

2. **What Information We Collect**: As an essential part of our business, we obtain certain personal information about you in order to provide a service to you. Some of the information comes directly from you, on applications or other forms, and may include information you provide during visits to our agency or while speaking with our staff. We may also receive information from physicians and other health providers or agencies. The types of information we receive may include addresses, a social security number, family information, current and past clinical history, and financial information.

3. **What are Treatment, Payment, and Health Care Operations?** Treatment includes sharing information among health care providers involved in your care. For example, your nurse may disclose information about your condition with a pharmacist or an outside physician to discuss appropriate medications. Bering Omega may also disclose your medical information as required by Medicaid or another entity, such as a health plan, for that entity's determinations concerning, for example, medical necessity or the entity's payment responsibility. We may also use and disclose your medical information to improve the quality of care at Bering Omega, for example, for review and training purposes.

4. **How Will Bering Omega Use My Medical Information?** Your medical information may be used or disclosed, unless you ask for restrictions on a specific use or disclosure, for the following purposes:

   - Family members or close friends who may consent to your treatment consistent with state and federal law.
   - As required by law.
   - Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence (if you agree or as required or authorized by law).
   - Health oversight activities, *e.g.*, audits, inspections, investigations, and licensure.
   - Lawsuits and disputes. (We will attempt to provide you advance notice of a subpoena before disclosing the information.)
   - Law enforcement (*e.g.*, in response to a court order or subpoena).
   - To coroners and medical examiners.
   - Certain research projects approved by an Institutional Review Board.
   - To prevent a serious threat to health or safety.
   - To military command authorities if you are a member of the armed forces.
   - National security and intelligence activities.
   - Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.
   - Workers' Compensation. (Your medical information regarding benefits for work-related illnesses may be released as appropriate.)
   - To carry out treatment, payment, and health care operations functions through business associates, *e.g.*, to install a new computer system.

   Certain types of information may be subject to additional restrictions on disclosure, such as AIDS or HIV test results, status or other related information and psychotherapy notes.

5. **Other Ways Bering Omega May Use My Medical Information.** In addition, Bering Omega may contact you to provide appointment reminders and to inform you of treatment alternatives or benefits or services related to your health that may be of interest to you. (You will have the opportunity to refuse to receive this information.)

6. **Your authorization is Required for Other Disclosures.** Except as described above, we will not use or disclose your medical information unless you authorize Bering Omega in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.

7. **You have Rights Regarding Your Medical Information.** You have the following rights regarding your medical information, provided that you make a written request to invoke the right on the form provided by Bering Omega:

   - **Right to request restriction.** You may request limitations on your medical information we use or disclose for health treatment, payment or operations, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
   - **Right to confidential communications.** You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.
   - **Right to inspect and copy.** You have the right to inspect and copy your medical information regarding decisions about your care. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; in some cases you may request review of the denial by another licensed health care professional chosen by Bering Omega. Bering Omega will comply with the outcome of the review.
   - **Right to request amendment.** If you believe that the medical information we have about you is incorrect or incomplete, you may request an amendment on the form provided by Bering Omega, which requires certain specific information. Bering Omega is not required to accept the amendment.
   - **Right to accounting of disclosures**. You may request a list of the disclosures of your medical information that have been made to persons or entities in the past six years, but not prior to April 14, 2003 (such list will not include disclosures made pursuant to an authorization or for treatment, payment, and health care operations). After the first request, there may be a charge.
   - **Right to a copy of this Notice.** You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice at our web site, www.beringomega.org.

8. **Requirements Regarding This Notice**. Bering Omega is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. Bering Omega may change this Notice, and these changes will be effective for medical information we have about you as well as any information we receive in the future. Each time you visit Bering Omega for health care services, you may receive a copy of the Notice in effect at the time.

9. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with Bering Omega or with the Secretary of the United States Department of Health and Human Services. *You will not be penalized or retaliated against in any way for making a complaint to Bering Omega or the Department of Health and Human Services.*

Contact: Call Ann Reed, Vice President of Operations at 713-341-3777 if:

- you have a complaint;
- you have any questions about this Notice;
- you wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- you wish to obtain a form to exercise your individual rights described in paragraph 6.

____________________	____________________	____________
Signature	Print Name	Date

Bering Omega Dental Clinic

1427 Hawthorne
Houston, Texas 77006
phone 713/341-3790 fax 713/524-7995

PHYSICIAN STATEMENT

Patient Name: ____________________________________ SS#: ______________________

Date of Birth: ___________________________

Physician Name: __________________________________ Phone # ___________________

The patient's diagnosis is (**please circle one**): AIDS HIV+

Date of most recent C.B.C.: ___________________________

Required values:

Hgb ________________**(14.0 – 18.0 g/dl)** MCHC ________________(32.0 – 36.0 %)

Hct ____________________(40.0 – 54.0 %) **WBC** __________________**(4.5 – 12.0 /mm3)**

RBC __________________ (4.50 – 6/10 M/mm3) **Plt Cnt** _________________**(150.0 – 400.0 /mm3)**

MCV __________________(82.0 – 101.0 03) **CD4** ________________ **Date** ____________

MCH __________________ (27.0 – 34.0 PG) **HIV Viral Load** _________ **Date** __________

Please list all patient medications: ____

____

DO YOU FEEL THAT THE PATIENT IS MEDICALLY FIT FOR THE PURPOSES OF RECEIVING DENTAL CARE AND/OR ORAL SURGICAL PROCEDURES?

YES NO

IF NOT, WHAT DO YOU SEE AS THE CONTRAINDICATION?
____
____

Physician Signature: ________________________________ Date: _______________

Print Physician Name: ______________________________

Revised 01/10