COMMUNITY HEALTH CENTER
Of The New River Valley

# School- Based Health Center (SBHC)
# Medical and Oral Health Program

## What is the School-Based Health Center (SBHC)?

Getting health care for your student can be complicated. Many medical offices only offer appointments during the school day, and their offices might be far from school. To see the doctor, your student may have to miss school and you might have to leave work — which isn't always an option. School-Based Health Centers are exactly what the name implies: a doctor/dentist's office conveniently located in your student's school. Students learn better when they are healthy – one of the best ways to keep students in class and learning is to bring quality services to them in the school.

Giles County students can receive medical appointments with the Community Health Center of the New River Valley at Giles High School. Our medical provider can treat for acute illnesses such as the flu or sore throat and chronic conditions, such as asthma or diabetes. The student may also obtain checkups, sports physicals, lab work, and receive prescriptions for an illness.

Oral health appointments will be offered at each school in Giles County. Our oral health provider will offer preventive dental services such as teeth cleanings, fluoride varnish applications, dental sealants, and oral health education.

The Community Health Center of the New River Valley will also provide referrals and coordination of follow-up medical and/or dental care for your student.

## How does the SBHC work?

The SBHC staff will coordinate with the school nurses to arrange medical and/ or oral health services. These services take place with a medical and/or dental provider in Giles High School (visits may be conducted via tele-health). After the visit, the SBHC staff will send the appointment information to the student's medical and/ or dental medical home. If the student does not have a medical or dental home, we will be happy to help the student become a patient at the Community Health Center of the New River Valley.

* Information from your student's visit will be shared with the school nurse, the student's regular dentist, the student's primary care provider, School-Based Health Center Staff, and the Community Health Center of the New River Valley for the purposes of billing, treatment and follow-up, and program monitoring.

# Community Health Center of the New River Valley

## SBHC Paperwork Checklist, 2021/2022

**Please make sure the following items are completed.**

**Appointments will not be scheduled until all necessary documents have been provided.**

☐ Completed Registration Form

☐ Copy of parent/guardian ID.

☐ Copy of **Front and Back** of insurance card(s)

☐ Signed Consent Forms

☐ Signed HIPAA Form and Consent for Minor and/or Adult with Guardian Form

☐ Completed Medical and Dental History Form

☐ Completed Sliding Fee Discount Program Application

**Please note if you are seeking Dental services and only enrolled in Medicaid, we highly recommend applying for the Discount Program since not all services are covered, if over the age of 21**

## There are **5** ways to return completed Student Paperwork:

1. Drop off at the student's school/send back with beginning of year packets.
2. Mail: Mail your completed application and accompanying documentation to the address below.
   *Community Health Center of the NRV*
   *Attn: School-Based Program*
   *219 S. Buchanan Street*
   *Pearisburg, VA 24134*
3. Fax: Fax to (540) 921-3503, Attn: School-Based Program
4. Email: Scan or take pictures of the completed paperwork and send to applications@chcnrv.org
5. Online: Fill out our online application at chcnrv.org

The Community Health Center of the New River Valley wants to ensure that patients are able to access affordable quality healthcare and realize that it is not always possible to physically deliver eligibility documents to Center sites. To promote access to care, the Center provides opportunities for patients to submit documentation via electronic transmission, including, but not limited to: faxZero, Center website, and email. Patients should understand that these electronic platforms may not be secured or HIPAA compliant. As a result, their information could be susceptible to third party breaches. If patients have questions regarding the potential risk of electronic communication, they may ask to speak with the Corporate Compliance Manager, Ashley Slagel-Perry at 540-381-0820.

**Student Name:** _____ **Student School:** _____

**I would like to enroll my student in (please circle): Medical Oral Health Both**

As the parent/guardian of the above-named student, I consent for them to receive medical and/or dental services through the Community Health Center of the New River Valley School-Based Health Program. I understand that consent to my student's participation provides consent for the following:

- The Community Health Center of the New River Valley to verify insurance before services are provided.
- The dental provider to perform dental cleanings, x-rays, fluoride treatments, and sealants.
- The medical provider to perform medical services, treatments, and prescribe medications for my student.
- The medical and/or dental provider to bill & collect payment from any Medicaid, private insurance, or other payer.
- The medical and/or dental provider to confidentially share my student's clinical information for billing purposes and/or to other clinical providers involved in my student's health care.

**Parent/Guardian Signature:** _____ **Date:** _____

**Parent/ Guardian Printed Name:** _____

**Community Health Center of the New River Valley - SBHC Patient Registration Form – 2021/ 2022**

| Student Information | Parent/Guardian Information |
|---|---|
| Name: _____<br>First MI Last<br>Nickname/Preferred Name: _____<br>Date of Birth: _____ / _____ / _____<br>Month Day Year<br>Social Security #: _____<br>Sex: ☐Male ☐ Female<br>Sexual Orientation (check one):<br>☐Straight ☐Lesbian/Gay ☐ Bisexual<br>☐ Something Else ☐ Don't Know<br>☐ Choose not to disclose Gender<br>Identity (check one):<br>☐Male ☐ Female ☐Other<br>☐Transgender Male ☐Transgender Female<br>☐ Choose not to disclose<br>Is the student a (check one):<br>☐U.S. Citizen ☐U.S. Resident ☐Other<br>What is the student's primary language? _____<br>Does the student require an interpreter? ☐Yes ☐No<br>Race (select all that apply):<br>☐African American ☐Native American<br>☐Asian ☐Pacific Islander<br>☐White ☐Other<br>Ethnicity (check one): ☐Hispanic ☐Non-Hispanic<br><br>Mailing Address: _____<br>City/State/Zip: _____<br><br>Street Address: _____<br>City/State/Zip: _____ | Mother<br>Name: _____<br>First MI Last<br>Father<br>Name: _____<br>First MI Last<br>Legal Guardian, If Applicable<br>Name: _____<br>First MI Last<br>Relationship of legal guardian to student:<br>_____<br><br>Contact Information for parent or guardian<br>Primary Phone: _____<br>☐Home ☐ Cell ☐Work<br>Secondary Phone: _____<br>☐Home ☐ Cell ☐Work<br>Email address: _____<br><br>☐ **Please register me for Patient Portal with the provided email address above.**<br><br>I give my permission for CHCNRV to contact me via (select all that apply):<br>☐Phone / voice mail ☐Text ☐Email<br>Who is the student's regular dentist? ☐ CHCNRV ☐ Other:<br>Dr. Name: _____<br>Telephone: _____<br>Address: _____ Who is the student's primary care provider? ☐ CHCNRV ☐ Other:<br>Dr. Name: _____<br>Telephone: _____<br>Pharmacy Name: _____<br>Pharmacy Phone #: _____ |

## Emergency Contact Information

| | |
|---|---|
| Name: _____<br>Relationship: _____<br>Phone: _____ ☐Home ☐ Cell ☐Work | Name: _____<br>Relationship: _____<br>Phone: _____ ☐Home ☐ Cell ☐Work |

## Insurance Information

**Does the student have Health/Dental Insurance? ☐ Yes ☐ No**

If yes:
Name of Insurance Company: _____ Insurance ID # _____ Group # _____
Policy Holder: _____ Relationship to patient: _____
Policy Holder's DOB: _____ Policy Holder's Sex: ☐Male ☐ Female

If no: My student currently does not have any medical or dental insurance coverage, whether through the government (Medicare or Medicaid), employment, or a private company. When I receive insurance coverage, I will notify the Community Health Center within 30 days of the start date of the new insurance and will provide a copy of my card. **Initial here:** _____

# Community Health Center of the New River Valley - SBHC Consent Form, 2021/2022

**Student Name:**_____**Birthdate:** _____

**CONSENT FOR TREATMENT**: I authorize the employees, agents and staff of the Community Health Center to perform and hereby consent to such medical treatment and examinations, including diagnostic procedures or behavioral health evaluations, as may in the opinion of the patient's physician be necessary.

**FLOURIDE CONSENT**: Please check **ONE:** _____ I give consent to apply fluoride treatment twice per year.
_____ I **DECLINE** fluoride treatment.

**TELEVISIT APPOINTMENT CONSENT**: I understand that a TeleVisit appointment involves the use of electronic devices such as a computer, tablet, smart phone or telephone to enable two-way communication between the patient and their provider at different locations for the purpose of diagnosis, treatment, therapy, follow-up and /or education. I consent for my medical, dental, and/or behavioral health provider at the Community Health Center of the New River Valley to conduct a health care appointment with me through a TeleVisit appointment. I understand that the laws that protect privacy and the confidentiality of my medical information also apply to TeleVisits. I understand that my insurance carrier will have access to my medical records for quality review/audit as they would with an in-person office visit. I understand that I will be responsible for any copayments, deductibles or coinsurances that apply to my TeleVisit appointment. I understand that I have the right to withhold or withdraw my consent for the use of TeleVisits during my care at any time, without affecting my right to future in-person care or treatment.

**NO GUARANTEE**: I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of any procedures, treatments, or examinations.

**RELEASE OF INFORMATION:** I authorize the center to release any and all patient medical, dental, and billing information/x-rays to any physician involved in my treatment; to any healthcare facility to which I/the patient is discharged or transferred to for treatment, billing, quality assurance, collection, or defense of litigation or anticipated litigation; and to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by the Community Health Center. I consent to the use and/or disclosure of my protected health information to carry out treatment, payment, or healthcare operations by the Community Health Center.

**DEEMED CONSENT FOR BLOOD TESTING**: I understand that under Virginia Law, if a healthcare provider, a person employed by, under the direction of, or control of a healthcare provider, is directly exposed to body fluids of a patient, which may transmit viruses causing HIV or Hepatitis B or C, the patient will be deemed to have consent for testing for HIV or Hepatitis B or C, and to the release of such test results to the person who was exposed. (Exposure could occur due to an accidental needle stick.) A patient who tests positive will be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

**FINANCIAL RESPONSIBILITY**: I understand that I am financially responsible for all charges, whether paid by insurance. The Community Health Center does not participate in **EVERY** insurance plan. I understand that I am responsible for verifying that the Community Health Center provider is a participating provider in my insurance plan. Patients are responsible for understanding benefits. Payment is expected at the time of service. I understand that I/the patient am responsible for any deductibles, co-payments, and any applicable percentage of remaining charges.

**DISCOUNT FEE PROGRAM**: Qualifying for our discount fee program based on your family income and family size may result in lower charges. You are required to report any income and family size changes to us as this may impact the amount you are expected to pay. We will review and update your information annually. Eligibility cannot be determined until we receive all requested information. If it is determined you are not eligible for the discount fee program and you have incurred charges, you will be expected to pay the balance due. We will assist you by arranging a payment plan if needed.

**CERTIFICATION AND ACKNOWLEDGEMENT**: I certify that all the above information and all information supplied by me, as part of the registration process, is correct. I also acknowledge receipt of the CHCNRV's Notice of Privacy Practices (HIPAA).

**BILLING INFORMATION:** It is important that you provide us with complete and accurate information (i.e. home address, phone numbers) so that we may properly submit billing data to your insurance company. We will make every effort to submit claims to your insurance company and promptly provide you with our statements. However, if for any reason the statement is returned to our office because of a problem with an address you provided, we will call you to secure full payment. Please ensure that all of your information is accurate and up to date. **Please be sure to bring your photo identification and your insurance cards to every visit** so that we may properly bill your insurance company. If you do not have your insurance card with you, you may be required to make payment in full that day.

**INFORMED CONSENT FOR INTEGRATED CARE SERVICES:** I understand that my provider works within a multi-disciplinary team, collaborating with social workers, care coordinators, and case managers as appropriate in order to ensure that my health care needs are most appropriately met. I understand that my integrated care team will regularly discuss my care and all team members have access to my protected health information (PHI) including, but not limited to, behavioral health/substance use disorder diagnoses and progress notes. I understand that all information regarding services is confidential and will not be released to any other agency or individual without my knowledge and consent, except when required by law (such as abuse and/or neglect of a person who is presently a minor or elderly, and/or serious intent of harm to self or others).

_____ _____

**Signature of Parent/ Legal Guardian** **Date**

_____ _____

**Relationship to Patient** **Witness Signature**

# Community Health Center of the New River Valley

**Student Name: _____Birthdate: _____**

## HIPAA

**Release of Information**

**List any person who we can talk to about your student's medical conditions (Protected Health Information) and their appointments. This *excludes Behavioral Health and Substance Abuse conditions (Sensitive Protected Health Information),* a separate release of information will need to be signed to discuss these with other individuals.**

| Name | Phone Number | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**By signing below, I agree that I have provided true answers to the best of my knowledge. It is my responsibility, as the student's guardian, to contact previous provider's offices for transfer of medical records. I have the ability to ask for a copy of my student's medical records at any time from CHCNRV. I have reviewed the Notice of Privacy Practices (HIPAA).**

Signature of Parent or Legal Guardian: _____ Date: _____

## Consent for Minor and/or Adult with Guardian

**Consent for treatment when Parent/Legal Guardian is not physically with the student**

**Student Name:** _____ **Birthdate**: _____

I (we) appoint _____ and/or _____ who is the
(Decision Maker Name) (Decision Maker Name)

student's _____ /_____ as my (our) proxy
(Relationship Guardian with student) (Relationship Guardian with student)

decision maker for consenting to nonurgent medical care for my (our) student with guardian listed above. I (we) have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent exercise the authority so delegated. Be advised that protected health information may be shared with the proxy to facilitate informed decision making.

**IN WITNESS WHEREOF, the undersigned have executed this instrument as the _____ day of _____, 20____.**

_____ _____
Parent or Legal Guardian Name Parent or Legal Guardian Signature

_____
Driver's License Number of Proxy Decision Maker

Community Health Center of the New River Valley

# Application for Discount Fee Program

Welcome to the Community Health Center of the New River Valley. We offer affordable health care and dental care through the use of a Discount Fee Program to all patients at or below 200% of the poverty level. All patients are eligible to apply for the discount fee program.

If you want to apply for the discount fee program, you must meet with a Patient Services Representative (PSR) who will review your patient packet and discount fee program application. At this time, the PSR can answer any questions you may have regarding the Discount Fee Program and how it works.

If you are applying for the discount fee program, please complete the attached Household Financial Information Form.

**You are required to bring proof of identification and ALL income that is received in your household.**

**Examples of Income:**

- Paycheck stubs for most recent full month of work
- Social Security Letter
- SNAP/WIC Benefits Letter
- Self -Employment Documentation (Taxes are Recommended)
- Letter from Employer on Company Letterhead
- Retirement/Pension
- Documentation of income from any other source
- If you have no income, we ask for a Letter of Support signed by the person who provides you with basic necessities

**Our Patient Services Representatives are available:**

Montgomery Center: Monday - Friday, from 8:30am to 4:30pm.
Pulaski/Radford Center: Monday - Friday, from 8:30am to 4:30pm.
Giles Center: Monday - Friday, from 8:00am to 4:00pm.

**All appointments are done on a walk-in basis.**

# Discount Fee Program Application

**Would you like to apply for our Sliding Fee Discount Program?** ☐Yes ☐No

If no, I understand that without having insurance and not applying for the Sliding Fee Discount Program, I will be responsible for my visits. I will be required to pay for my visits upfront, in full. If I have insurance, I will be responsible for any balance due after my insurance has been processed. Initial here: _____

***The Discount Fee Program is only available to Patients whose incomes fall at or below 200% of the Federal Poverty Line.**

How many people are in your family, including yourself? _____ Please list them below.

| Family Members: (include yourself) | SSN: | Date of Birth: | Relation | Monthly Gross Income* | Employer Name (if employed) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

***If someone can claim you as a dependent on their taxes, then list all other family members on that tax return.**

**Document and provide proof of all income received:** Paycheck stubs, Retirement, Social Security, Pension, Disability, Worker's Compensation, Unemployment, and ALL others not listed.
**Application will be rejected if documentation is not provided**.

## Employer and Income Information

Employer Name: _____ Employer Phone: _____
Date Employment Began: _____ Circle One: Full-Time Part-Time

How often are you paid? ☐Weekly ☐ Bi-weekly ☐Monthly ☐Bi-monthly ☐Other: _____
Amount you are paid before taxes: _____

Did your household file income taxes last year? ☐Yes ☐No Filing Status (circle one): Joint or Single

## Unemployment and Disability Information

If Unemployed, date employment ended: _____

Does anyone receive unemployment wages? ☐Yes ☐No If yes, how much? _____

If Unemployed, has anyone applied for Disability? ☐Yes ☐No

Are you or anyone in your family planning on applying for disability? ☐Yes ☐No

## Government Assistance and Insurance Information

Do you or anyone in your household have Medicaid? ☐Yes ☐No If yes, who? _____

Do you/spouse or any children under 18 receive Social Security Benefits? ☐Yes ☐No

Do you or others in the family have insurance? ☐Yes ☐No If yes, Name of Insurance: _____

The information provided is, to the best of my knowledge and belief, accurate and true. I authorize the release of all information which the Community Health Center may need to determine whether I qualify for financial assistance through their Discount Fee Program. I understand that eligibility in the program expires 12 months from my signature date below and that I must reapply after the eligibility period expires. I understand that I must inform the Center of any changes in my household (income and size) during this 12-month period.

Parent/ Legal Guardian Signature: _____ Date: _____

# Community Health Center of the New River Valley

**SBHC Health History Form, 2021/ 2022**

**Student Name:**_____**Birthdate:** _____

## Dental History

Is this your student's first visit to the dentist? ☐Yes ☐ No

If not, how long since the last visit to the dentist? _____

Were any x-rays taken at previous dental visits? ☐Yes ☐ No

Have there been any injuries to the teeth, face, or mouth? ☐Yes ☐ No

If yes, please explain. _____

_____

Do you have any dental concerns?_____

_____

Does the student have any of the following habits (check all that apply)?

☐ Lip Sucking / Biting ☐ Nail Biting

☐ Thumb / Finger Sucking

Has the student ever had a serious or difficult problem associated with previous dental work? ☐Yes ☐ No

If yes, please explain. _____

_____

Is the student's water fluoridated? ☐Yes ☐ No

Is the studet taking fluoride supplements? ☐Yes ☐ No

Has the student ever had any pain or tenderness in his/her jam/joint? (TMJ/TMD) ☐Yes ☐ No

Does the student brush his/her teeth daily? ☐Yes ☐ No

Floss his/her teeth daily? ☐Yes ☐ No

Please describe the student's current dental health (circle one): Good Fair Poor

## Health History

Medical Diagnosis:

| | |
|---|---|
| | |
| | |

What medications does the student take?

| Name of Medication | Dose of Medication | Time of day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Does the student have allergies to any medication?

| Name of Medication | Response to Medication |
|---|---|
| | |
| | |
| | |

Has the student ever had any of the following conditions?

| | | | | | |
|---|---|---|---|---|---|
| ☐**Yes** | ☐ **No** | Abnormal Bleeding | ☐**Yes** | ☐ **No** | Handicaps/Disabilities |
| **Yes** | ☐ **No** | Hearing Impairment | ☐**Yes** | ☐ **No** | Heart Disease/Murmur |
| ☐**Yes** | ☐ **No** | Any Hospital Stays | ☐**Yes** | ☐ **No** | Hemophilia/Blood Disorders |
| ☐**Yes** | ☐ **No** | Any Operations | ☐**Yes** | ☐ **No** | Hepatitis |
| ☐**Yes** | ☐ **No** | Asthma | ☐**Yes** | ☐ **No** | HIV +/AIDS |
| ☐**Yes** | ☐ **No** | Cancer | ☐**Yes** | ☐ **No** | Kidney/Liver Conditions |
| ☐**Yes** | ☐ **No** | Congenital Birth Defects | ☐**Yes** | ☐ **No** | Rheumatic/Scarlet Fever |
| ☐**Yes** | ☐ **No** | Convulsions/Epilepsy | ☐**Yes** | ☐ **No** | Allergies to Latex Product |
| ☐**Yes** | ☐ **No** | Pregnancy | ☐**Yes** | ☐ **No** | Diabetes |
| ☐**Yes** | ☐ **No** | Tuberculosis | | | |

Any other health conditions not mentioned above:

## Consent to Exchange Written and Verbal Information

**Student Name:** _____ **Date of Birth** _____

COMMUNITY HEALTH CENTER
Of The New River Valley

I hereby authorize the staff of CHCNRV at 219 South Buchanan St. Pearisburg, VA 24134 (Phone: 540-921-3502 Fax: 1-540-921-3503) to: ☐Provide ☐Request written or verbal information **from or to:**

Name/Title: _____Fax #: _____

Mailing Address (if applicable):_____

**Dates of records to disclose:** ☐All **OR** From _____To _____

**The nature of information to be disclosed:** ☐ Progress notes ☐ Treatment plans ☐ Assessments
☐ Medical information ☐ Treatment summary ☐ Psychiatric notes ☐ Drug test results
☐ Diagnostic evaluations
☐ Other _____

**The purpose of this disclosure is**:
☐ Treatment planning ☐ Provide case management ☐ Report on progress ☐ Determine disability

☐Determine recommendations for further treatment ☐ Other: _____

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I further understand that CHCNRV cannot condition the provision of treatment to me on my signing of this authorization. This consent is valid unless revoked by me prior to the expiration date, but not retroactive to information already released. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent unless the recipient is a provider who makes a disclosure permitted by law. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. This consent extends to information placed in my record after my consent was given but before it expires. I also understand that my records are protected under State and Federal substance abuse confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I agree that a photocopy of this form is as valid as the original.

**NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42CFR PART 2).**

**THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION**

**UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON**

**TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2. A GENERAL AUTHORIZATION**

**FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. THE FEDERAL RULE RESTRICTS ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE CLIENT.**

☐ This consent is good for one year from the effective date. ☐ This consent is only valid until _____

(A date less than 12 months)

_____

Client, parent, guardian or legally authorized representative Effective Date

_____

Witness / Title or Credentials /Date:

**You may revoke this authorization at any time by signing and dating a written request.**

# Community Health Center of the New River Valley

## Informed Consent for General or Remote Supervision.

"I understand that the records for services provided by the dental hygienist will be reviewed by a Virginia licensed dentist providing the hygienist general supervision. I understand that treatment I receive from the dental hygienist is limited in scope and that it does not take the place of a regular dental examination or treatment by a licensed dentist. I understand that the dental hygienist may refer _____ (name of patient) to a dentist or other specialist for further treatment when a dental condition requires more treatment that the dental hygienist can provide."

_____ Signature of Patient or guardian

_____ Date Signed

Agreement Between Dentist and Hygienist:

(1) The dental hygienist will practice according to the parameters set forth in this agreement.

(2) The dentist providing general supervision must be available for consultation but is not required to be physically present at the site where dental hygiene services are provided.

(3) The dental hygienist working under this agreement and supervising dentist agree to maintain communication and consultation with each other.

(4) The hygienist will provide the dentist opportunities to review patient records as requested.

(5) The dentist will review the records of patients treated by the dental hygienist from the beginning of general/remote supervision. Reviews will include records of all patients seen. Reviews must occur no less than once every 10 (ten) months at a minimum. The dentist may determine the need for and conduct more frequent reviews. Subsequent reviews of records need only encompass patients seen since the last review.

(6) Limitation on treatment:

(a)When the patient's dental condition requires services beyond what the hygienist can provide, the hygienist will advise or refer the patient to obtain dental or other care.

(b) For patients who have been treated by a hygienist under general/remote supervision and since treatment began have not been seen or examined by a dentist in the last 10 months, the hygienist should inform the patient or guardian that an examination by a dentist is strongly recommended if not required in some cases.

If a school or institution obtains consent for dental hygiene services provided at its facilities, the dental hygienist shall make and document reasonable efforts to ensure that the consent form used by the school or institution provides an equivalent notice and that patients, parents or guardians are aware of the information in the consent form above.