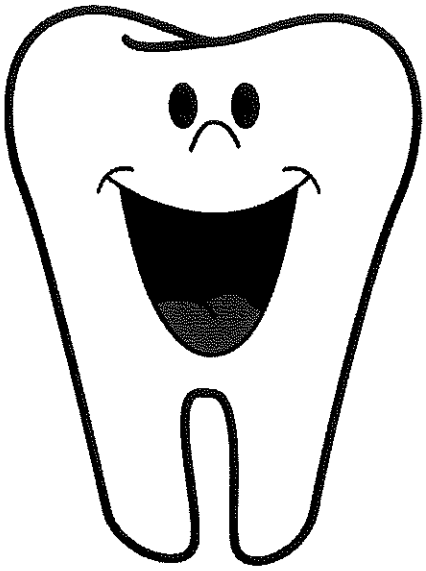


OIL CITY AREA SCHOOL DISTRICT
DENTAL SUITE

LOCATION: Oil City High School
WHEN: Every Tuesday

WHAT SERVICES ARE PROVIDED?

Preventative services* offered:

- Screenings
- Digital X-Rays
- Prophylaxis
- Cleanings
- Fluoride Treatments
- Sealants

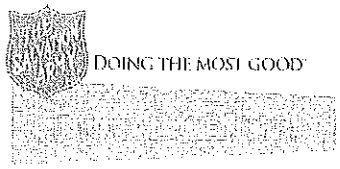
*Note: Referrals are given for needed services

HOW TO MAKE APPOINTMENT?

Complete the attached paperwork and return it to your child's school. All insurances are accepted!

TRANSPORTATION: Provided to OCHS for elementary students!

Reminder: The Pennsylvania Department of Education requires **MANDATORY** dental exams for students in Kindergarten, grade 3, and grade 7. The OCASD Dental Suite can help students meet this requirement.



PLEASE FILL OUT AND RETURN AS SOON AS POSSIBLE

Dear Parent/Guardian,

Please check the following services that you permit your child to have administered at the Oil City High School Dental Suite:

____ Screening

____ Digital x-rays

____ Prophylaxis

____ Fluoride Treatment

____Sealants

_____ _____

Child's Name (printed) Date

_____ _____

Parent/Guardian Signature Relationship to Patient

Please have your child seen by his or her dentist within the next 30 days for an exam from the doctor!

Referral Information

How did you hear about our practice? ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Radio

Would you like to receive information about other Salvation Army Programs? ☐ Yes ☐ No

Would you like someone from the Salvation Army ministry to call on you? ☐ Yes ☐ No

Parent/Guardian Information AND Insurance Information—Private Insurance Only

Name: _____

Relationship to patient: ☐ Self ☐ Parent ☐ Spouse ☐ Legal Guardian

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street City State ZIP Code

Insurance Plan: _____ Group Number: _____

Claim Mailing Address: _____ City _____ State ___ Zip Code _____

Name of Policyholder: _____ Subscriber ID # _____

Employment Information—Need if Insurance is through your Employer

The following is for: ☐ Self ☐ Parent/Guardian or other person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Acknowledgement of Payment for Services and Consent for Treatment

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. This practice will not discriminate against any person receiving dental services because of their inability to pay for services or because payment for the dental services will be made under title XIX ("Medicaid") of the Social Security Act. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

Dental services, including emergency services will be provided at a nominal or reduced charge to persons unable to pay for services upon completion of an application for financial aid and submission of proof of income and family size including but not limited to a tax return (within the past 2 years), unemployment letter, denial letter from Medical Assistance, disability award, social security award, payroll stub, or other as determined by the Salvation Army Dental Center Director. If financial assistance is granted, the patient agrees to adhere to all scheduled appointment times and terms of the financial arrangements. Any breach defined by a "no show" appointment or failure to make payments as scheduled may result in termination of financial assistance.

Patients presenting a valid identification card for dental insurance understand that all dental services will be charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. Checks received by the patient from the insurance carrier should be turned over to this practice for reimbursement of treatments completed. This dental office cannot render services on the assumption that charges will be paid by an insurance company. In the event of non-payment for dental services, the practice reserves the right to suspend of terminate the patient.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of completed services to the Salvation Army Dental Center at the time services are rendered, or within Thirty (30) days of billing if credit shall be extended.

I grant my permission to you or your assignee, to telephone me at home, at my work or on your cell phone to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____

Signature of Patient or parent/guardian or other responsible party

_____

Printed Name Relationship to Patient

Referral Information

How did you hear about our practice? ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Radio

Would you like to receive information about other Salvation Army Programs? ☐ Yes ☐ No

Would you like someone from the Salvation Army ministry to call on you? ☐ Yes ☐ No

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Printed Name Relationship to Patient