Kelly H. Toombs, D.D.S., P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:____

Address:____

Telephone:_________________________ E-mail:_____________________

Patient Number:_____________________ Social Security Number:_____________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: Cindy Foss
Telephone: 913-381-5292 Fax: 913-381-5293
E-mail: toombsortho@gmail.com
Address: 3700 W. 83rd Street, Prairie Village, KS 66208

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ___________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature:____ Date:_________________
If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _______________________________________

Relationship to Patient:____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.
Signature:____ Date:_________________

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SUPPLEMENTAL
INFORMED CONSENT

Orthodontic Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

☐ Yes ☐ No

Patient Name

Parent/Guardian Name *(if applicable)*

Relation

Patient/Parent/Guardian Signature

Date

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CLEAR FORM

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SUPPLEMENTAL HEALTH QUESTIONNAIRE

Orthodontic Treatment in the Era of COVID-19

If you have been exposed to a communicable disease, you may spread the disease to the orthodontist, orthodontic staff or other patients/parents in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission:

Do you, your child, others accompanying you today or anyone else you have recently been in contact with have any of the following symptoms?

- **Fever** ***(defined as above 100.4° F degrees)*****?** ☐ Yes ☐ No
- **Chills?** ☐ Yes ☐ No
- **Cough?** ☐ Yes ☐ No
- **Sore Throat?** ☐ Yes ☐ No
- **Shortness of breath and/or trouble breathing?** ☐ Yes ☐ No
- **Persistent muscle pain, pressure or tightness in the chest?** ☐ Yes ☐ No
- **New loss of taste or smell?** ☐ Yes ☐ No

Have you or others accompanying you to today's appointment traveled outside of our local area or outside of the US within the past 14 days? ☐ Yes ☐ No

Have you, your child, others accompanying you today or anyone you have recently been in contact with tested positive for or been diagnosed as having COVID-19 or any other communicable disease? ☐ Yes ☐ No

If yes provide approximate dates of illness __________ through __________

symptom start date symptom end date

☐ I understand that if the answer to any of these questions is yes, I may be asked to reschedule today's orthodontic appointment to a later date.

____
Patient Name

____________________ __________
Parent/Guardian Name *(if applicable)* Relation

____________________ __________
Patient/Parent/Guardian Signature Date

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