School-Based Health - Dental Care
Permission to Treat

NAME:_____ **STUDENT DOB**:_____

I HEREBY AUTHORIZE AND CERTIFY THE FOLLOWING:

1. I give consent for my child to receive preventive dental care at school via mobile unit. In a joint effort with ***Pittsylvania County Schools*** & Piedmont Access To Health Services (PATHS), Inc. will offer exams, cleanings, fluoride, x-rays, and, where appropriate, sealants to help prevent decay. I understand that any other dental needs (fillings, braces (orthodontic care), or extractions) will be referred to a dental office chosen by the parent/guardian for treatment.

2. I understand that I am financially responsible for the dental services and will provide insurance information and/or Medicaid evidence of coverage. In the event no insurance is current, I am aware that I can apply for reduced costs through a sliding fee scale.

3. I authorize the release of any medical information necessary to process an insurance claim for payment of benefits to PATHS, Inc.

4. I authorize payment of insurance benefits for services rendered by PATHS, Inc.

5. I understand that all my child's records will be strictly confidential, and maintained in compliance with state and federal laws, including HIPPA and FERPA.

6. **I want my child to receive the following preventative dental care:**
   (Check ✓ all that apply)

☐ EXAM ☐ CLEANING ☐ XRAYS ☐ FLUORIDE

Please sign the following declaration: By signing this form, I authorize my child to receive preventive dental care services in my absence. I understand that this consent is voluntary and is valid for the entire time that my child is enrolled in school. I understand that I may also revoke my consent, in writing, at any time. I understand that it is my responsibility to provide up-to-date information on the insurance coverage I carry on my child, including Medicaid.

Parent/Guardian Signature:

_____

Signature **Date**

Revised 9/2023