Missed Appointments:

I understand repeated cancellation of appointments or missed appointments are subject to missed appointments fees ($5 for primary care / $10 for specialty care) and/or practice dismissal in accordance with state regulations.

Conditions of Acceptance for the VCU/HU School of Dentistry:

The Free Clinic hosts the student teaching program of the Virginia Commonwealth University School of Dentistry (VCU), as well as the Howard University School of Dentistry (HU). As a dental patient at the Free Clinic, you may be provided care by students or residents under the supervision of a licensed dentist. By signing this form, you agree to participate as a patient in this program, which includes screening exam and, if eligible, subsequent treatment.

I understand that the purpose of the screening exam is to determine whether I can be accepted for care in the student teaching program of the VCU and/or HU School of Dentistry. I understand that acceptance is based upon the educational objectives and needs of the academic program. If accepted, I agree to notify the dental clinic the day before the appointment (24) hours if I must cancel that appointment. I also understand that repeated cancelation or excessive tardiness may be cause for dismissal from the Dental program.

I understand and agree that my records and the records pertinent to my treatment are the property of the VCU and/or HU School of Dentistry; however, upon written request, the dental school will provide me with copies of my record.

I hereby give consent to be photographed, filmed, or videotaped in connection with the treatment, education, and research program of the VCU and/or HU School of Dentistry. I understand and agree that all such photographs, films and tapes are the property of the VCU and/or HU School of Dentistry.

I understand and agree that for the purposes of the VCU and/or HU School of Dentistry's Quality Assurance Program staff charged with the oversight of quality assurance activities will review my records to ensure that standards of care have been met.

I further understand and agree that the VCU and/or HU School of Dentistry and its faculty shall be permitted to use all or part of my patient record, either in photographic form or in scientific writing, for publication or scientific journals, or for the advancement of dental education. All personal information will be protected to prevent identification of the patient either directly or indirectly.

MORE INFORMATION

THIS NOTICE IS EFFECTIVE April 13, 2020

For more information, contact Community Access Network and the Free Clinic at
(434) 200-3366 or write to us at 800 5th Street, Lynchburg, VA 24504.

I have received a copy of Community Access Network and the Free Clinic of Central Virginia Notice of Privacy Practices. I understand that Community Access Network and the Free Clinic of Central Virginia have the right to change this Notice of Privacy Practices from time to time and that I may contact Community Access Network and the Free Clinic at any time to obtain a current copy of the Notice of Privacy Practices.

I have verbally notified the Community Access Network and Free Clinic of Central Virginia of my personal contacts who are permitted to access my medical information.

I have read and understand the information provided above regarding consents to treatment and other consents, and all of my questions have been answered to my satisfaction.

To be signed by patient or legal guardian if patient is a minor under the age of 18, or legally unable to give informed consent.

Patient/Legal Representative Signature: _____

Legal Representative Printed Name: _____

Date: _____