Memorandum of Understanding

S. K. Pesis DDS, Big Smiles Maryland PC
and
Howard County Public School System

This Memorandum of Understanding ("MOU") is entered into and effective as of September 1, 2017 by and between S. K. Pesis DDS, Big Smiles Maryland PC ("Smile Maryland") and Howard County Public School System (HCPSS). Smile Maryland and HCPSS may be individually referred to as a "party" and collectively referred to as the "parties."

S. K. Pesis DDS, Big Smiles Maryland PC ("Smile Maryland") mission is to increase the quality of children's lives by providing dental services to children often left without care. Dental cleaning, screening and fluoride is generously provided for charity care to children-in-need. No child is ever turned away for lack of resources.

The purpose of this memorandum is to establish an understanding between Smile Maryland and HCPSS to provide comprehensive oral services to Howard County Title 1 elementary school enrollees in kindergarten through fifth grade. The program is designed to provide preventative and simple restorative services as outlined below. The program will provide enrollees a dental home and provide follow up care to those enrollees who require treatment or referral.

Smile Maryland agrees to:

- Collaborate with the HCPSS Health Services to select a mutually agreed upon date to provide
    - Preventive and restorative dental services at no charge to HCPSS for elementary school students, including:
        - exams, cleanings, fluoride treatments
        - x-rays and sealants where applicable
        - simple fillings
        - pulpotomies on baby teeth, baby teeth extractions and pulp caps
    - Dental care only to the children who have turned in a parental/guardian signed consent as indicated on the student's permission form (Attachment A).
    - All materials and supplies needed to execute the program according to clinical standards of care for comprehensive dental services and infection control protocols.

- A dental home for students participating in the program for follow up care, treatment and referral purposes
- Administrative support and billing functions for insurance payments for services rendered.
  - When available, Medicaid covers 100% of treatment. Most insurances are accepted.
  - When children-in-need without insurance or Public Aid receive charity care funding, then dental screenings, cleanings and fluoride treatments are provided at no expense, with parental signature and a written statement of financial need. Insurance co-pays and deductibles that apply may also be covered by charity care.

- Ensure that each site is served by licensed Maryland dentist and hygienists.
- Provide each participating student a "report card" for their parents' review including documentation of the services and findings
- Maintain documentation of the services and findings for each student participating in the Smile Maryland program according to clinical standards of care for record maintenance.
- Not share publically any data, findings, or information associated with this program without first receiving written authorization from HCPSS.

Howard County Public School System agrees to:

- Distribute Permission Forms (Appendix A) to students in the fall and spring semesters of each school year and at other times upon request, as well as to collect the Permission Forms from the students in advance of the dental visit, and to send the completed Permission Forms to Smile Maryland as far in advance of the dental visit as reasonably possible.
- Assist families with completing the appropriate consent forms, thus providing valid consensual authority for Smile Maryland to perform dental services on each child seeking care.
- Provide space in the school, suitable for the staff of Smile Maryland to set up its "dental office".
- Provide a minimum of 20 children per site to be treated. If minimum is not reached, the visit may be revised or cancelled.

Insurance and Indemnification.
Each party shall purchase and maintain comprehensive general liability insurance and professional liability insurance in the minimum amounts of One Million Dollars ($1,000,000.00) per occurrence. Smile Maryland and its employees (and certain contractors) are covered by the Federal Tort Claims Act for claims arising out of negligent acts and omissions committed in the course of providing health services to Smile Maryland patients. Upon request, each party shall provide the other party evidence of its insurance coverage.

Each party agrees to indemnify, defend and hold harmless the other party, and its directors, officers, agents and employees from and against any liability, loss, expense (including reasonable attorneys' fees), or claims for injury or damages arising out of the party's performance of this MOU to the extent such liability, loss, expense or claims for injury or damages are caused by or result from the negligent or intentional act or omission of the indemnifying party.

Compliance with Laws and Regulations
Each party shall comply with all applicable local, state and federal laws, rules, regulations and guidelines pertaining to the subject matter of this MOU. Should laws be amended so as to modify this MOU, such amendment shall be incorporated herein and be immediately effective between the parties.

Discrimination
The parties hereby agree that no person shall, on the basis of race, color, creed, national origin, religion, physical or mental disability, age, gender, marital status, or sexual orientation, be excluded from or denied participation in or otherwise subjected to discrimination in relation to any activity associated with this Agreement.

Confidentiality
Both parties shall maintain the confidentiality of all individually identifiable health information in accordance with federal and state laws, including HIPAA and the HITECH Act.

The parties agree not to disclose, except to each other, any proprietary information, professional secrets, or other information obtained in any form during the course of carrying out the responsibilities under this MOU, unless written permission is obtained in advance. This provision shall survive the term of the agreement.

If activities described in this MOU are funded by grant money, both parties shall retain records in accordance with applicable laws and make such records available to funders as may be necessary to certify the nature and extent of the cost of services provided hereunder.

Term and Termination
The term of this MOU shall commence on the date first set forth above and continue in full force and effect until terminated by the parties in accordance with the provisions herein.

If this MOU is contingent on the award or continuation of grant funding and the grant is not awarded, this MOU will be considered null and void. If funding is lost during the duration of the term of the MOU, the MOU will be similarly voided unless the parties agree in writing to its continuation.

This Agreement may be extended or modified upon written agreement of the Parties. However, no amendment or modification of this Agreement shall be effective unless in writing.

Either party may terminate this MOU at any time by giving the other party at least 30 days prior written notice in advance of the termination date and specifying the date of termination.

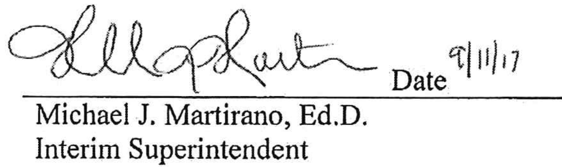
Authority
Each signatory to this MOU represents and warrants that he or she has the authority to act for, sign, and bind the respective entity on whose behalf he or she is signing.

S. K. Pesis DDS, Big Smiles Maryland
PC8639 B 16th Street #271
Silver Spring, MD 20910

Date 9/14/17

S.K. Pesis, DDS
Dental Director

Howard County Public School System
10910 Clarksville Pike
Ellicott City, MD 21042



Date 9/11/17

Michael J. Martirano, Ed.D.
Interim Superintendent

APPENDIX A

Taking care of your child's teeth is important to keep them healthy.

EASY & CONVENIENT - A state licensed dentist will regularly check your child's mouth & teeth, as well as provide a cleaning, x-rays as necessary, fluoride treatment and apply sealants, as needed. Additional care, such as fillings, may also be provided. A dental report card will be sent home with your child. Includes initial dental care & follow-up visits. **SIGN AND RETURN TO YOUR SCHOOL TODAY!**

PLEASE COMPLETE

Child's Legal Name		Birth Date	☐ Male ☐ Female
Address	City	State	Zip
School	Teacher		Grade
Parent/Guardian Name		Phone ( )	
Email		Alt Phone ( )	

IMPORTANT HEALTH QUESTION

Does your child have any past or present medical or dental conditions or disabilities? This may include heart issues, breathing problems, brain/seizure disorders, allergies (including drug allergies), diabetes, bleeding problems, communicable diseases or immune disorders etc. If Yes, explain below (attach additional pages as needed). IF NO, LEAVE BLANK.

____

FOLD

List current medications ______________________ **List any dental concerns** ______________________

FOLD

IF CHILD HAS MEDICAID/MARYLAND HEALTHY SMILES

Enter Child's 11-digit Medicaid Recipient ID Number HERE: → ☐☐☐☐☐☐☐☐☐☐☐

***Medicaid & Maryland Healthy Smiles Program cover 100% of treatment**

OR Child's Social Security # (if available) ☐☐☐ - ☐☐ - ☐☐☐☐

IF CHILD HAS PRIVATE DENTAL INSURANCE

Ins. Company name (other than Medicaid)______________________ Ins. Phone______________

Group #______________ Employer name______________ Co. phone______________

Name of Insured Adult______________ **BIRTH DATE of Insured Adult** ______________

Member ID/Policy #______________ Social Security # of insured adult ______________

IF CHILD HAS NO DENTAL INSURANCE

(ALSO CHECK ONE BELOW) If paying for services, staple check or money order to this form & make payable to: Smile Maryland.

☐ I will pay the reduced fee for a dental cleaning, screening & fluoride per visit. Ages 13 or younger: **$68.00** Ages 14 or older: **$84.00**

☐ I request donated care to cover the cost of a dental cleaning, screening and fluoride for my child. (We will send you a donated care application. Available only once per school year for preventive care only.)

If your child sees a dentist regularly, and you want to continue care with that dentist, you should do so.

READ & SIGN BELOW

I request that the dentist perform a dental check-up on my child at school which includes exam, cleaning, fluoride, sealants and x-rays as needed, as well as other dental work as needed, including fillings, extractions of infected baby teeth, numbing the mouth and teeth and other procedures as described more fully on the back of this page. This permission includes future dental visits. I have read the IMPORTANT HEALTH QUESTION above and will report any significant changes in my child's health to 855-481-8639. I have also read the IMPORTANT NOTICE AND CONSENT ON THE BACK OF THIS PAGE and understand and agree to its terms.

SIGN & DATE HERE ______________________ ________ **DATE**

For your privacy, please fold & secure.

QUESTIONS:1-888-833-8441 **FAX: 1-888-330-4331** **Visit us at: mobiledentists.com**

S.K. Pesis D.D.S., General Dentist & Dental Director, Big Smiles Maryland, PC
8639 B 16th St. #271, Silver Spring, MD 20910
©S.K. Pesis D.D.S.,Big Smiles Maryland, PC, 2016

ESPAÑOL AL REVERSO

MD-COMPR-009v2-PDF

IMPORTANT NOTICE & CONSENT / AVISO IMPORTANTE Y CONSENTIMIENTO

I understand and authorize S.K. Pesis D.D.S., Big Smiles Maryland, PC (Provider) and its affiliated dentists to provide the following services for the named child for whom I am the custodial parent or legal guardian: dental exam & oral hygiene instruction, teeth cleaning, fluoride treatment, x-rays & dental sealants. I authorize the dentist to fill any cavities or to place a crown over the tooth if needed. I authorize Provider to extract any problem baby teeth or perform a pulpotomy (treatment of the nerves inside the tooth) as needed. I understand that there are risks to dental treatment including swelling or pain that may occur from the injection of a local anesthetic or allergic reaction. (For additional information regarding the risks of treatment and treatment alternatives, please call the number provided.) I authorize & direct Provider to bill & collect payment from any Medicaid, insurance, or other payer. If I have private dental insurance, I will be billed for & agree to pay any deductibles and/or co pays. Treatment by the in-school dentist may affect future benefits that your child may receive under private insurance, Medicaid or CHIP. Unless I have made pre-arrangements to attend, and am there at the time of service, services will be provided without my presence. We may send you text messages about the school dental program. Message and/or data fees may be charged by your wireless service provider; to discontinue, reply "STOP" to any message received from us.You also agree to receive pre-recorded and/or auto-dialed telephone calls relating to the school dental program at the land-line and/or mobile telephone numbers provided on this consent form. I have received the Notice of Privacy Practices (NPP) attached to this form and consent to the release of my child's medical record information, including records obtained from other providers, and any HIV/AIDS, communicable disease, sexually transmitted disease, drug and alcohol, and anemia information. I authorize release of such information by Provider to any responsible payor and/or administrative service provider and their subcontractors for use and disclosure relating to my child's treatment, payment for services and health care operation purposes. This signed consent authorizes my child's initial and future dental visits. I may withdraw this consent at any time in writing.

Entiendo y autorizo a S.K. Pesis D.D.S., Big Smiles Maryland, PC (Proveedor) y a sus dentistas afiliados a proveer los siguientes servicios al niño(a) mencionado del cual soy el padre custodio o tutor legal: examen dental, limpieza de los dientes, tratamiento de fluoruro, rayos-x y sellantes. Autorizo al dentista a que atienda cualquier carie o coloque una corona sobre el diente si es necesario. Autorizo al Proveedor a extraer cualquier diente de leche con problema o realizar una endodoncia (tratamiento de los nervios dentro del diente), como sea necesario. Entiendo que existen riesgos al recibir tratamientos dentales incluyendo inflamación o dolor que puede ocurrir de la inyección de la anestesia o una reacción alérgica. (Para información adicional sobre los riesgos del tratamiento dental y tratamientos alternos por favor llame al número proporcionada.) Autorizo y dirijo al Proveedor a facturar y recolectar pago de Medicaid, seguro privado o tercera persona. Si tengo seguro dental privado, seré facturado y acuerdo a pagar cualquier deducible y/o co-pago. El tratamiento realizado por el dentista escolar pudiera afectar los beneficios de su niño en en un futuro bajo su cobertura privada, Medicaid o CHIP. Al menos de que allá hecho algún arreglo previamente para atender y estoy ahí al momento de los servicios, el servicio será proveído sin mi presencia. En ocasiones podremos mandarle un texto sobre el programa dental escolar. Cobros de mensaje o/y de datos pueden ser aplicados por su proveedor de servicios inalámbrico; para descontinuar, responda "STOP" a cualquier mensaje que reciba de nosotros. Usted también acepta recibir transmisión pre grabada y/o auto llamadas telefonicas relacionadas con el programa dental escolar a los numeros telefónicos que usted proporciono en esta forma de consentimiento. He recibido el Aviso de Prácticas Privadas (NPP) adjuntas a este formulario y el consentimiento para la divulgación de la información y/o expediente médico de mi hijo(a), incluyendo los registros obtenidos de otros proveedores, y cualquier otra enfermedad como: VIH/SIDA, enfermedades contagiosas, enfermedades de transmisión sexual, drogas, alcohol, y anemia. Yo autorizo la divulgación de dicha información por parte de proveedores para cualquier pagador responsable y/o proveedor de servicios administrativos y de sus subcontratistas para el uso y divulgación de información relacionada con el tratamiento de mi hijo(a), pago para el mantenimiento y operación de cuidado dental. Esta forma de consentimiento firmada autoriza la visita dental inicial y visitas de seguimiento. Puedo retirar mi consentimiento en cualquier momento por escrito.

KEEP FOR YOUR RECORDS

SOLOMON PESIS, DDS - GENERAL DENTIST, DENTAL DIRECTOR

General Dentists - Renee Campbell, DDS, Reginald Cole, DDS, Eve Desai, DDS, Pareen Dholoo, DDS, Jennifer Enlow, DDS, Brian Garriques, DDS, Charles Knapp, DDS, Frank Lewis, DDS, Melissa Lin, DDS, Saima Malik, DDS, Corey Murray, DDS, Doanh Ogle, DDS, Dede Oraca-Tetteh, DDS, Solomon Pesis, DDS, Ernest Ponraj, DDS, Nisar Qamruddin, DMD, Edward Roth, DDS, John Sawchuk, DDS, Sheetal Solanki, DDS, Roland Swann, Jr., DDS, Yvonne Tanner, DDS, Yumna Valuifa, DDS, Vachon Walker, DDS, Angela Wiredu, DDS, Daniel Workie, DDS, Amir Zolfeghari, DDS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. KEEP FOR YOUR RECORDS

OUR LEGAL DUTY

The privacy of your medical information is important to us. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. We will notify you if your unsecured medical information is breached.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician, school nurse, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our business operations such as reviewing the competence or qualifications of healthcare professionals and evaluating practitioner and provider performance.

Your Authorization: Uses or disclosures not otherwise described in this Notice may be made only with your written authorization. In addition, we must obtain your written authorization to sell your medical information or to use or disclose your information for marketing goods or services to you where we are paid to make the communication. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends and Persons Involved in Your Care: We may disclose your health information to a family member, friend or other person involved in your care to the extent necessary to help with your healthcare or with payment for your healthcare. We may also disclose your medical information to disaster relief organizations to help locate individuals during a disaster. We may also use or disclose your medical information to notify, or assist in the notification, of a family member, a personal representative or a person responsible for your care of your location, general condition or death. If you do not want us to disclose your medical information to family members or others in these circumstances, please notify our HIPAA Officer at 888-833-8441.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Safety: We may need to disclose medical information to law enforcement officials, such as in response to a search warrant or a grand jury subpoena, or to assist law enforcement officials in identifying or locating an individual, to report deaths that may have resulted from criminal conduct, and to report criminal conduct on our premises.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose your medical information to military authorities of Armed Forces or foreign military personnel under certain circumstances; to authorized federal officials for lawful intelligence, counterintelligence, or other national security activities; and to protect the president; and to a correctional institution or law enforcement official having lawful custody of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters, emails or text messages).

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure surveys. These activities are necessary for the government to monitor the health care system, the outbreak of disease, government programs, compliance with civil rights laws and to improve patient outcomes.

Lawsuits and Disputes: We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process.

Other Uses and Disclosures. As permitted or required by law, we may use or disclose your medical information for research purposes; to organizations that handle and monitor organ donation and transplantation; for workers' compensation or similar programs to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness; for public health activities such as to prevent or control disease, injury or disability; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to, or is at risk for contracting or spreading a disease; to medical examiners to identify a deceased person or determine cause of death; or to funeral directors to carry out their duties.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information and fax your request to the number at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of some disclosures we or our business associates have made of your health information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we restrict our use or disclosure of your health information. We are not required to agree to your request except when disclosure would be to your health plan, you (or someone on your behalf other than your health plan) has paid in full for your health care, the disclosure relates to payment or health care operations, and the disclosure is not otherwise required by law. If we agree to the restriction, however, we will abide by that agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations specified in your written request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: HIPAA Officer

Phone: 888-833-8441

Fax: 888-330-4331

email: hipaaofficer@smileprograms.com

Effective Date: August 1, 2016