PATHS
Live Life. Be Healthy.

PATHS Community Dental Center

705 Main Street
Danville, VA 24541
Ph.434-791-0214 Fax 434-791-0217

380 Washington Street
Boydton, VA 23917
Ph.434-738-6332 Fax 434-738-6330

www.pathsinc.org

PATHS Community Dental Center is a general dentistry facility offering affordable dental treatment for adults and children. We accept all dental insurance including DentaQuest (Medicaid Virginia Premier). For those who do not have dental insurance we offer a sliding scale based on household income and the number of people living in the home.

The following is a brief description of services offered at PATHS Dental Center:
(A slide scale is used for basic services no matter the number of services used in that one hour visit.)

Basic Services include: Slide A-$50, Slide B-$60, Slide C-$70, Slide D-$80, Slide E-$100

- Emergency Exam (one tooth) with one PA xray
- Comprehensive Exam (full mouth) with all xrays
- Simple Extractions
- Restorations begin both resin and amalgam
- Simple Prophy & Fluoride Adult
- Simple Prophy & Fluoride Child
- Debridment (deeper cleaning)
- Deep scaling & Root planning per quad

Major Services include: Slide A-50%, Slide B-40%, Slide C-30%, Slide D-20%, Slide E-10%

- Crowns
- Bridges
- Partials
- Dentures

Registration Information:

- **Hours: Paper work can be picked up and dropped off any time during hours of operation. The dental staff will process the applications on Thursdays 1:30 –3:30 and Fridays 8:30 – 3:30**
- New patients will need to be registered **before** scheduling appointments.
- **Only** complete registration packets will be scheduled appointments.

Complete registration packets include:

- Proof of Household Income Pay stubs (choose **one**)
  - A) 1 month of most recent, B) most recent tax returns, or C) bank statements (state if it came from Social Security, Disability, or employer)
- No income proof — The SNAP acceptance letter, or any organization that uses income as a qualification. A family member, friend, significant other, minister, etc. who would be willing to verify that the patient has no income at this time.
- Dental Insurance or Medicaid Card- bring card (s) to verify eligibility.
- Medication List: Need name of medicine, strength, direction on how taken, what condition taken for, doctors name and phone numbers.

PATIENT MEDICAL INFORMATION

Name: _____ Age: _____ DOB: _____
Weight: _____ Height: _____ Influenza Virus Given: ☐ Yes ☐ No If yes, date: _____

List Health Conditions:

Condition	Age of Diagnosis	Status

List Medications Currently Using:

Name	Strength	Frequency	Taken When?	Prescriber	Prescriber Phone #

Family History Information:

		Sibling	Child	Living	Deceased	List Medical Conditions They Have Or Have Had
Mother						
	Father					

F. Patient Medical History

Primary Care Physician: _____ Phone: ( ) _____-_____ Date of Last Visit: ___/___/___

1. Are you currently under medical treatment for any condition? ☐ Yes ☐ No
2. Have you been hospitalized for any surgical operation or illness within the past 5 years? ☐ Yes ☐ No
3. Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No
4. Have you taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates? ☐ Yes ☐ No
5. Have you taken Viagra, Revati, Cialis, or Levitra in the last 24 hours? ☐ Yes ☐ No
6. Do you use tobacco? ☐ Yes ☐ No If yes, ☐ Light smoker ☐ Heavy Smoker ☐ Ex-smoker When did you quit? _____
7. Do you use controlled substances? ☐ Yes ☐ No
8. Are you hearing impaired? ☐ Yes ☐ No
9. Are you vision impaired? ☐ Yes ☐ No
10. Do you have a persistent cough/throat clearing not associated with a known illness? ☐ Yes ☐ No
11. Are you allergic, or had reactions to any of the following:

☐ Yes ☐ No Aspirin	☐ Yes ☐ No Erythromycin	☐ Yes ☐ No Percocet
☐ Yes ☐ No Benzocaine	☐ Yes ☐ No Fluoride	☐ Yes ☐ No Prophy Paste
☐ Yes ☐ No Cipro	☐ Yes ☐ No Food	☐ Yes ☐ No Seasonal Allergies
☐ Yes ☐ No Clindamycin	☐ Yes ☐ No Iodine	☐ Yes ☐ No Sulfa
☐ Yes ☐ No Codeine	☐ Yes ☐ No Latex	☐ Yes ☐ No Tetrocycline
☐ Yes ☐ No Darvocet	☐ Yes ☐ No Local Anesthetic	☐ Yes ☐ No Tylenol
☐ Yes ☐ No Epinephrine	☐ Yes ☐ No Penicillin	☐ Yes ☐ No Z-pak

12. Do you have, or had any of the following:

☐ Yes ☐ No ADD/ADHD	☐ Yes ☐ No Epilepsy/Seizures	☐ Yes ☐ No Hormone Therapy
☐ Yes ☐ No Anemia	☐ Yes ☐ No Excessive Bleeding	☐ Yes ☐ No Jaundice
☐ Yes ☐ No Angina	☐ Yes ☐ No Fibromyalgia	☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Arthritis	☐ Yes ☐ No General Allergies	☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Artificial Joints	☐ Yes ☐ No Glaucoma	☐ Yes ☐ No Lupus
☐ Yes ☐ No Asthma (Use Inhaler)	☐ Yes ☐ No Growths	☐ Yes ☐ No Menopause
☐ Yes ☐ No Back/Spine Injury	☐ Yes ☐ No Hay Fever	☐ Yes ☐ No Mental Disorder
☐ Yes ☐ No Blood Disease	☐ Yes ☐ No Heart Disease/Problem	☐ Yes ☐ No Migraines
☐ Yes ☐ No BPH/Prostate Health	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Cancer (Kind?) _____	☐ Yes ☐ No Herpes	☐ Yes ☐ No Neurological Disorder
☐ Yes ☐ No Diabetes	☐ Yes ☐ No High Blood Pressure	☐ Yes ☐ No Pregnancy
☐ Yes ☐ No Dizziness/Fainting Spells	☐ Yes ☐ No High Cholesterol	☐ Yes ☐ No Stroke
☐ Yes ☐ No Endometriosis	☐ Yes ☐ No HIV	

WOMEN ONLY:

13. Are you pregnant, or think that you may be pregnant? ☐ Yes ☐ No If yes, anticipated due date? _____
14. Are you nursing? ☐ Yes ☐ No
15. Are you taking oral contraceptives? ☐ Yes ☐ No

I give the dentist and/or hygienist permission to use local anesthetic as needed: ☐ Yes ☐ No

By signing below, I certify that I have read and understand the above medical history questionnaire. I understand that this information will be used by PATHS Community Dental Center staff to help determine appropriate and healthful dental treatment. If there are any changes in my medical status, I will inform PATHS Community Dental Center immediately.

Patient/Guardian Printed Name: _____

Patient/Guardian Signature: _____ Date: _____

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Today's Date: ___/___/____

Which services are you interested in? ☐ Medical ☐ Dental ☐ MEDAssist ☐ Pharmacy ☐ CHAAP

Who would you like to choose as your primary care provider? _____

What pharmacy do you prefer to use? ☐ PATHS Community Pharmacy ☐ Other _____

A. Patient Information

Name: _____ Birthday: ___/___/___

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Other ☐ Choose not to disclose

SS Number: _____-_____-_____ Phone: (Primary) (___) ___-_____ Secondary: (___) ___-_____

Address: _____ City: _____ ST: _____ Zip: _____

Email Address: _____

Do you live in public housing? ☐ Yes ☐ No ☐ Homeless

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ More than one race ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Unreported/Refused to report race

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Hearing Impaired ☐ Vision Impaired ☐ Interpreter Needed

Sexual Orientation: **Does not apply to patients under 18*** ☐ Straight (not lesbian or gay) ☐ Lesbian or Gay ☐ Bisexual ☐Something Else ☐ Don't know ☐ Choose not to disclose

Are you a veteran: ☐ Yes ☐ No Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Employment Status: ☐ Full Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Disabled

Employer (or Name of School if Minor): _____

Are you a student? ☐ Yes ☐ No: If yes, ☐ Full-Time ☐ Part-Time

Are you a migrant/seasonal worker? ☐ Yes ☐ No

B. Responsible Party

Name of Person Responsible for this account: _____

Phone: (H) (___) ___-_____ Cell: (___) ___-_____

Relationship to Patient: _____ Birthday: ___/___/___ SS Number: _____-_____-_____

Address: _____ City: _____ ST: _____ Zip: _____

Is this person also a patient in another of PATHS services? ☐ Yes ☐ No If yes, which one _____

C. Insurance Information

Primary Insurance

Name of Insured: _____ Relationship to Patient: _____ Birthday: ___/___/___

SS # _____-_____-_____ Insurance Company: _____

Secondary Insurance

Name of Insured: _____ Relationship to Patient: _____ Birthday: ___/___/___

SS # _____-_____-_____ Insurance Company: _____

Do you have prescription coverage? ☐ Yes ☐ No

How do you prefer to be contacted? ☐ Mail ☐ Phone ☐ Email ☐ In Person

In the event of an emergency while you are in our office, who should we contact?

_____

Name Relationship

_____

Address City ST Zip

(___)_____-_____ (___)_____-_____ (___)_____-_____

Phone: Home Phone: Other Phone: Work

Please read the following carefully:

I HEREBY AUTHORIZE AND/CERTIFY THE FOLLOWING:

1. PATHS Community Medical/Dental Center, a division of Piedmont Access to Health Services, Inc. (PATHS), through its appropriate personnel and/or medical staff to perform, administer, or prescribed upon to or for me any member of my family (including minor children) whose names appear above, such examination, tests, immunizations, injections, and diagnostic procedures as are deemed necessary. I also certify that all information contained herein is true and correct to the best of my knowledge and belief and that no facts have been omitted.

2. Insurance Authorization and Assignment: PATHS Community Medical/Dental Center to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical /dental services rendered to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.

3. Medicare Lifetime Authorization: for physical services and request that payment or authorized Medicare benefits be made either to me or on my behalf to PATHS for any services furnished to me by their physicians. I authorize my holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

4. Deemed Consent for Designated Blood borne Pathogens: Virginia law requires health care providers to notify you that Hepatitis B and C or HIV (AIDS virus) testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility. Under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for PATHS Community Medical Center is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Centers for Disease Control, may transmit HIV or Hepatitis B or C, PATHS will proceed to test the patient's blood for HIV and Hepatitis B and C. PATHS will provide the results of the test to the patient through his or her primary care provider and to the health care worker who was exposed. PATHS' policy also protects you as a patient, should you be exposed to the body fluids of a health care worker.

5. Private Health Information: I certify that I have been informed of the policies and procedures related to how PATHS Community Medical/Dental Center, a division of Piedmont Access To Health Services, Inc., may use and/or disclose my personal health information.

6. I give my MEDAssist Case Worker the authority to contact my physician (s) and exchange any information necessary in order to apply for free medications through The Pharmacy Connection. I also give my MEDAssist Case Worker the authority to exchange information with the pharmaceutical companies that manufacture my medications in an effort to access free medication.

7. I authorize my MEDAssist Caseworker to sign any necessary forms on my behalf when ordering medications for me through The Pharmacy Connection. I understand that this will speed up the ordering process by making it unnecessary for the forms to be sent to me and then back to MEDAssist. This signature authorization is valid as long as I am receiving services thorough MEDAssist.

8. Your signature below authorizes PATHS to obtain medical records and/or dental x-rays from Danville Regional Medical Center, Memorial Hospital of Martinsville and Henry County, Sentara Halifax Regional Hospital and VCU Health Community Memorial Hospital for the purpose of continuity of care.

9. Consent to Obtain External Prescription History/E-Prescribing Consent: By authorizing PATHS Community Medical/Dental Center, you allow us to view your external prescription history via the RxHub Service. This will provide the physician with information about medications the patient is already taking to minimize the number of adverse drug effects. By signing this form, you are agreeing that you understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and staff here, and it may include prescriptions back in time for several years. By signing this form, you are agreeing that PATHS can request and use your prescription history from other healthcare providers and/or third part benefit payers for treatment purposes.

The information provided on this registration form is true, accurate, and complete to the best of my knowledge.

All inclusive signature: _____ Date: ____ / ____ / _____

POLICIES THAT MAY AFFECT YOU

PATHS is working hard to make sure that all our patients have access to the highest quality care possible. We want to make sure that you are well informed of the policies we have implemented that will help make that possible.

1. Phone Calls: We are committing to you as a patient, that anytime you call our office, your questions will either be answered immediately, or if it's necessary to leave a message, we will return your call within one business day.

2. Medication Refill Requests: Please help us manage your medication needs by allowing enough time before running out of your medication. Please contact your pharmacy to request a refill. Your provider at PATHS will be notified electronically. **This process may take up to three business days.**

3. Appointment Times: We will do our best to provide you with an appointment at a time that is convenient for you. If you are more than 15 minutes late arriving for your appointment, we may have to reschedule your appointment.

4. "No Show" Appointments: A no-show is defined as the client failing to keep a scheduled appointment without prior notification of the need to cancel. A scheduled appointment means any appointment scheduled for the client with the PATHS Community Medical/Dental Center staff. Exceptions will be made for circumstances beyond the control of the client, such as family emergencies, extreme illnesses, death in the family, or transportation difficulties. In this case, the client should make every effort to notify the Medical/Dental Center of the reason for the missed appointment as soon as possible.

5. Medical Center No-Show: If a no-show happens two or more times in a six month period, we will ask that you take advantage of our walk-in access system. This means that you will not be able to schedule an appointment at a particular time, but can come in, register, and wait. Our staff will make every effort to work you in to be seen.

6. Dental No-Show: A no-show as defined above applies to the Dental Center as well. If the patient no-shows a second appointment without notification the patient will be sent a letter of dismissal from the Center. The letter will include a list of providers the patient may qualify for and will be seen at PATHS for the next 30 days for emergency care only.

7. Sliding Fee Scale: If you do not have insurance, or cannot afford your co-pays/deductibles, you can apply for our sliding fee scale. Based on your household income, we may be able to reduce our fees for you. In order to apply, you will need to provide proof of income for everyone in your household. You do not have to apply for sliding fee scale, however, you will be responsible for 100% of our routine charges until you do. If you choose to apply and are approved, you will need to reapply once a year.

8. Narcotic Prescription Medications: As a rule, PATHS providers will not write prescriptions for pain pills, Xanax-type drugs, or other controlled substances.

9. Collection Policy: PATHS is committed to providing access to care for everyone in our community regardless of their *ability* to pay. This is accomplished by providing the opportunity for you to apply for the sliding fee scale. From that point, it is important that you clearly understand the importance of meeting your financial obligations as they relate to your care at PATHS. If you do not pay your bills on time and are *unwilling* to set up a payment plan, PATHS may refer your account to a third party agency for assistance in collecting. Continued unwillingness to pay may leave us with no choice other than to discharge you. If you are concerned that this may affect you, please see a member of our staff, or call our office for assistance immediately to avoid being discharged.

10. PCMH: I understand that PATHS will be my "Patient Centered Medical Home." I have been given information as to what this means to PATHS, and acknowledge understanding of what is expected of me.

_____ _____/_____/_____

Signature *Date*

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SLIDING FEE SCALE APPLICATION

If you have insurance and do not wish to apply for the sliding fee scale please initial here: _____

Patient Name (Printed): _____ Date: ____ / ____ / _____

Date of Birth: ____ / ____ / _____ **Do you file taxes? ☐ Yes ☐ No**

How many in your household are dependent on this income? _____ (include yourself)

Please complete the following:

Name (Spouse): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

How often do you get paid? ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually ☐ Does not apply

Please list your net income for everyone in your household:

Salary Wages:	$_____	Social Security:	$_____
Interest on Savings Accounts:	$_____	Dividends on Investments:	$_____
Pension	$_____	Personal Business Profits:	$_____
Rental Income:	$_____	Disability:	$_____
Unemployment:	$_____	Alimony:	$_____
Veteran's Benefits:	$_____	Child Support:	$_____
Aid to Dependent Children:	$_____	SSI:	$_____
Other: _____	$_____	Other: _____	$_____

Total Annual Income: $_____

The information provided concerning the size of my family and my family's net annual income from all sources is true, accurate, and complete to the best of my knowledge. I realize that PATHS Community Medical/Dental Center will rely on such information to determine how much my account will be discounted. I realize that knowingly giving false information in this case may result in criminal prosecution under the laws of Virginia. I agree to report any change in either my income or my family size to PATHS. PATHS may initiate a review of my payment status at any time to verify the information I have provided.

Signature: _____ Date: ____ / ____ / _____

For Front Desk Use Only: Sliding Fee Scale Expiration Date: ____ / ____ / _____ Initial:_____

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Your **Patient Centered MEDICAL HOME**

Welcome to your medical home!

Patient centered is PATHS way of saying that you, the patient, are the most important person in the health care system. You are at the center of your health care. A medical home is an approach to providing total health care. Caring for you when you are well physicals and preventive screenings, and when you are sick (acute-i.e. sore throat, cold) or have on-going health concerns (chronic-i.e. high blood pressure, diabetes). We will even see that you get the care that you need if we don't have the skills to meet your need (specialty care i.e. diagnostic testing or specialists like neurology).

With your medical home at PATHS, you will join a team that includes health care professionals, trusted friends or family (if you choose), and-most importantly-you. The health care system can be confusing and a lot of people can start feeling lost in the system after visiting with several doctors. The medical home team will listen to your questions and can help you find your way through the system.

A. What PATHS medical home will do for you:

1. Your medical home team will know you and your family and can provide you with total health care. You will see the same team each time you visit, and they can help answer your health questions.
2. If you need to see a specialist, your team can keep in touch with that specialist to make sure you get the care you need.
3. We will track your care using computers and electronic records so that all of your records will be in one place.
4. You will be able to reach your team when you need them:
   - By patient portal if you have access to a computer with the internet; via e-mails; and access to your health information 24/7. Safe, secure, and just for you.
   - During regular office hours that include extended hours:
     - Boydton: Monday, Thursday and Friday 8:00 to 5:00; Tues & Weds. 8:00-8:00
     - Chatham: Monday, Wednesday, Thursday & Friday 8:00-5; Tues 8:00 to 7:00
     - Danville Monday 8:00 to 7:00, Tues-Friday 8:00-5:00
     - Martinsville: Monday-Friday 8:00 to 5:00
     - South Boston: Monday-Friday 8:00 to 5:00
   - After-hours communications include:
     - Calling your local office for the answering service; or
     - Use of the Patient Portal at: https://mycw10.eclinicalweb.com/portal422/jsp/login.jsp.
       (For more information about Patient Portal ask the front desk.)
5. PATHS medical home will be the coordinator of all your care—the one place where you can learn about and have access to information about your medications, visits to specialist, medical history, health status, recent tests, self-care information, information from recent hospitalizations, specialty care or ER visits. PATHS can be your store house or go to place for every aspect of your care—a one stop shop if you will.

B. With a medical home you and your team work together. It is not a passive or one sided relationship.

1. You will have a chance to explain things that are important to you.
2. You will have your questions answered in a way that will help you better understand your health needs.
3. If you need help from other doctors your PATHS medical team will support you every step of the way.
4. You will have convenient office hours to help you get an appointment that suits you.

C. **Together, you and your team can work out a plan just for you, including:**
   1. Personalized health care that meets your needs.
   2. Tracking of your care.
   3. Many ways to keep in touch with your health care team.

Commit to your PATHS medical home team by contracting with them to be a team participant as they commit to you by being your personalized medical home, providing you with all the things discussed as well as a quality, evidenced-based care, and support for your own self-management of your health and health care needs.

Working with your team may improve the quality of health care and shorten the time it takes to get that care.

Remember, the medical home can be a way for you to be informed about and involved in your health care decisions. The medical home can bring you, your family, and your health care team together to help you make the best choice about your health.

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This document contains information pertaining to policies and procedures that apply to how PATHS Community Medical Center operates in terms of providing your health care. If you have questions about anything you read, please ask our staff during your appointment, or by phone.

PRIVACY PRACTICES/HIPAA POLICIES:
This notice describes how health information about you may be used and disclosed and how you can get access to this information. If you have any questions about this notice, please contact PATHS Community Medical Centers' Privacy Officer.

Though your health record is the physical property of the facility that compiles it, you have the right to:

- Inspect and Copy: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain, very unique, circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by PATHS Community Medical Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- Amendments: If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by PATHS Community Medical/Dental Center. We may deny your request for an amendment, but if this occurs, you will be notified of the reason for the denial.
- Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment, or health care operations.
- Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care for the payment of your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at work or by US Mail. The facility will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing. The written request must include a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize we reserve the right to contact you by other means and other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Changes to this Notice: We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you, as well as any information we receive in the future. The current notice will be posted in PATHS Community Medical/Dental Center and will include the effective date. In addition, each time you register at our facility for treatment or health care services, updated copies of this notice will be available by request.