APPLICATION FOR TREATMENT Chart #

Orofacial and Oral Medicine Center

Herman Ostrow School of Dentistry of USC

Patient Information (To be completed by the patient – Please PRINT in ink)

Mr. [ ] Mrs. [ ] Ms. [ ]
Last Name: _____ Date: ____/____/____

First Name: _____ Middle Name: _____

Home Address:

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Preferred Phone: ( ) _____

Email address: _____

Driver's License: _____

California ID: _____ [ ] Other _____

Passport: _____

Employer: _____

Work address _____

Sex: [ ] Male [ ] Female [ ] Other

Birth date: _____

Primary Language(s) Spoken: _____

Are you associated with USC? Yes / No (please circle)

If so, how? _____

Ethnicity: (please select)
[ ] Asian [ ] Caucasian
[ ] Hispanic [ ] Other
[ ] African American
[ ] American Indian/Alaskan native
[ ] Pacific Islander
[ ] Unknown

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone :( ) _____

Major dental problem/reason for coming to Herman Ostrow School of Dentistry of USC: _____

Referring Physician Dentist: _____ Phone: ( ) _____

Referring Office or Clinic Name _____

Address: _____ City: _____ State: _____ Zip: _____

Please Initial to authorize consultation report to be sent to physician _____

Patient signature (Parent or legal guardian's signature if patient is under 18 years of age) _____

Insurance/Financial Information (To be completed by patient-Please PRINT in ink

Previously a patient here? [ ] Yes [ ] No Year _____

Medical Insurance _____ Plan #: Group #:

Subscriber: _____ Subs # Subs. Birthdate:

Relationship to patient: _____

Person Responsible for Payment: _____ Phone: _____

Dental Carrier Name: [ ] Delta [ ] Delta/USC [ ] Denti-Cal [ ] Other _____

Please be aware that your insurance may not pay for the total amount of your treatment and you may be responsible for any co-pays or amount that your insurance company does not cover. If you elect to have treatment that is not a covered benefit, you are responsible for the full cost of the treatment.

Revised 1/17 SG

School. Patients must also provide personal identification that may include their social security numbers to process dental insurance claims and/or to request patient record information.

Dental Records: The dental records, x-rays, photographs, videos, models, and other diagnostic aids that relate to your treatment here, are the School's property. You have the right to inspect these aids and/or request a copy of them. The School may charge a reasonable administrative fee for this service. You may also request to have your dental x-rays sent to another health care provider by completing an ACCESS REQUEST FORM. The School is authorized to furnish information from your records to your insurance company to obtain financial reimbursement for treatment provided to you. In addition, your dental records may be used for instructional or research purposes and, if they are, the School will use reasonable efforts to keep your identity confidential from individuals not involved in your care and treatment.

Keeping Your Appointments: You are required to be on time for your appointments. If you find that you are unable to keep an appointment you agree to notify the student doctor, student dental hygienist, or the appointment assistant at least 24 hours in advance. A total of three cancellations without 24-hour notice, three missed appointments, or repeated unsuccessful attempts to arrange an appointment may be cause to discontinue your dental treatment at the School.

Discontinuance of Treatment: The School reserves the right to discontinue your dental treatment. Should your treatment be stopped, any remaining credit balance for services not yet provided will be refunded to you.

Grievances: If you have concerns that your student doctor or dental faculty member cannot resolve, please contact our Patient Advocate in the Office of Clinical Affairs at telephone number 213-740-1547 or via email: patientfeedback@usc.edu

Security: You understand that for security purposes cameras are present throughout the School.

Release: You hereby agree to release, hold harmless and waive all claims, losses, or damages resulting or relating to the treatment rendered hereunder by the student doctor, resident, student dental hygienist, faculty or School. The undersigned certifies that he/she has read and is willing to comply with the foregoing, and is the patient, the parent or guardian of the patient with authority to give consent, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms. In addition, you acknowledge that you received a copy of the School's PATIENT BILL OF RIGHTS.

Patient signature:_____ Date:_____

Parent/Guardian signature: _____ Date:_____
(if Patient is under 18 years of age)

Student dentist signature:_____ Date:_____

Witness (Faculty) signature: _____ Date:_____

Medical History Questionnaire

Herman Ostrow School of Dentistry of USC

Patient Name: _____ Date of Birth: _____

Reason for visiting the School of Dentistry: _____

Please answer all questions **by checking a box under YES or NO.** (Please do not draw a line.)
Your responses will be held strictly confidential and will only be used to help assess your medical condition. If you have any hesitations, please express your concern to a member of our team.

Do you have, or did you ever have, any of the following?

Cardiovascular:

YES	NO	
☐	☐	High blood pressure
☐	☐	Heart disease from childhood
☐	☐	Heart murmur
☐	☐	Rheumatic fever
☐	☐	Use of Phen-Fen
☐	☐	Pacemaker
☐	☐	Vascular graft
☐	☐	Heart valve replacement
☐	☐	Heart attack
☐	☐	Heart surgery
☐	☐	Congestive heart failure
☐	☐	Angina (chest pain)
☐	☐	Irregular heart beat
☐	☐	Stroke
☐	☐	Increased cholesterol

Endocrine/Hematologic/ Oncologic/Immune:

YES	NO	
☐	☐	Frequent hunger
☐	☐	Frequent thirst
☐	☐	Diabetes
☐	☐	Thyroid disease
☐	☐	Hemophilia
☐	☐	Sickle cell disease
☐	☐	Bleeding tendency
☐	☐	Anemia
☐	☐	Cancer
☐	☐	Radiation therapy
☐	☐	Chemotherapy
☐	☐	HIV infection/AIDS
☐	☐	Organ transplant
☐	☐	Blood transfusion

Do you have, or did you ever have, any of the following?

Musculo-Skeletal/CNS/Developmental:

YES	NO	
☐	☐	Chronic jaw and facial pain
☐	☐	Chronic headache pain
☐	☐	Chronic neck pain
☐	☐	Popping or clicking in your jaw
☐	☐	Joint replacement
☐	☐	Osteoarthritis
☐	☐	Rheumatoid arthritis
☐	☐	Spinal cord injury
☐	☐	Seizures
☐	☐	Dizziness
☐	☐	Weakness
☐	☐	Multiple Sclerosis
☐	☐	Cerebral palsy
☐	☐	Intellectual Disability
☐	☐	Dementia / Alzheimer's
☐	☐	Fainting spells
☐	☐	Visual impairment
☐	☐	Glaucoma
☐	☐	Hearing impairment

Gastro-Intestinal/Genito-Urinary:

YES	NO	
☐	☐	Hepatitis (A, B, C, or other?)
☐	☐	Kidney dialysis
☐	☐	Ulcers
☐	☐	Sexually transmitted disease
☐	☐	Denied permission to give blood

Psychological:

YES	NO	
☐	☐	Anxiety / Nervousness
☐	☐	Depression
☐	☐	Mental health treatment
☐	☐	Insomnia

Respiratory:

YES NO

- ☐ ☐ Asthma
- ☐ ☐ Chronic Sinus Problems
- ☐ ☐ Night sweats
- ☐ ☐ Emphysema
- ☐ ☐ Tuberculosis

Other: _____

Social:

YES NO

- ☐ ☐ Do you use tobacco products?
  If so, how much? _____
- ☐ ☐ Do you drink alcohol?
- ☐ ☐ Every day?
  If so, how much? _____
- ☐ ☐ Do you use recreational drugs?

Medication Allergy or Intolerance:

YES NO

- ☐ ☐ Penicillin
- ☐ ☐ Dental anesthetic ("Novocain")
- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Latex products
- ☐ ☐ Iodine

Other: _____

_____

Do you have any medical conditions not already mentioned?

_____

_____

History of Hospitalization/Surgical Procedures:

_____

_____

Family: Did a parent, sibling or child of yours have any of the following?

YES NO

- ☐ ☐ Diabetes
- ☐ ☐ High blood pressure
- ☐ ☐ Heart disease
- ☐ ☐ Bleeding tendency
- ☐ ☐ Cancer

Medications:

YES NO

- ☐ ☐ Are you taking any prescription medicines, any over-the-counter items, or any herbal medicines now?

If so, please list them and the doses you use:

_____

_____

_____

_____

_____

_____

Do you or have you used bisphosphonate medication (i.e. Fosamax®, Actonel®, Boniva®, Skelid®, Didronel®, Aredia®, Zometa® and Bonefos®) to prevent or treat osteoporosis or as part of a cancer treatment?

YES NO

☐ ☐

(If **"yes"**, please ask your student for an informational page about bisphosphonate medications – oral and/or intravenous)

Other:

YES NO

- ☐ ☐ Does the amount of saliva in your mouth seem to be too little?
- ☐ ☐ Does your mouth feel dry when eating a meal?

FEMALES ONLY:

YES NO

- ☐ ☐ Are you pregnant now?
  If so, #_____months
- ☐ ☐ Do you take birth control pills?
- ☐ ☐ Are you breast feeding now?

To the best of my knowledge, all of the preceding answers are true. If I have any change in my health status, or any change in my medicines, I will inform my dental health care provider at my next appointment.

_____ _____

Signature of patient (or Parent or Guardian if patient is under 18) Date

_____

Faculty: signature, number, and name PRINTED **Student/ Resident: Signature, number, and name PRINTED**

USC School of Dentistry - Orofacial Pain and Oral Medicine Center
925 W. 34th Street- 1st floor; Los Angeles; CA, 90089; Tel: 213-740-3410; Fax: 213-740-3573

OFP-OM Supplemental Medical History Questionnaire

Patient Name: _____ _____ Date of Birth: _____

Past/Current Medical Disease History: Do you have, or did you ever have, any of the following?

YES NO

Cardiovascular:
- ☐ ☐ Atherosclerotic disease
- ☐ ☐ Heart valve defect or prolapse
- ☐ ☐ Infection of heart (endocarditis)

Hematologic/Oncologic/Immune:
- ☐ ☐ Hypoglycemia
- ☐ ☐ Hypercoagulability
- ☐ ☐ Leukemia
- ☐ ☐ Idiopathic edema
- ☐ ☐ Unusual immune suppression
- ☐ ☐ Multiple Allergic Reactions
- ☐ ☐ Herpes (Oral/ Genital Herpes)
- ☐ ☐ Lyme disease
- ☐ ☐ Meningitis/encephalitis
- ☐ ☐ Osteomyelitis
- ☐ ☐ Pneumonia
- ☐ ☐ Upper respiratory infection

Musculoskeletal:
- ☐ ☐ Pinched or damaged cervical nerves
- ☐ ☐ Slipped Vertebral Disc
- ☐ ☐ Ankylosing Spondylitis
- ☐ ☐ Carpal Tunnel Syndrome
- ☐ ☐ Cervicogenic Pain/Headache
- ☐ ☐ Chronic Fatigue Syndrome
- ☐ ☐ Fibromyalgia
- ☐ ☐ Myofascial Pain Disorder
- ☐ ☐ Traumatic Local Arthritis
- ☐ ☐ Systemic Lupus Erythematosis
- ☐ ☐ Gout
- ☐ ☐ Psoriasis
- ☐ ☐ Osteoporosis
- ☐ ☐ Periodic Leg Movement Syndrome
- ☐ ☐ Raynaud's Disease

Neurologic/Degenerative/Developmental:
- ☐ ☐ Cluster Headaches
- ☐ ☐ Epilepsy
- ☐ ☐ Migraines
- ☐ ☐ Parkinson's Disease
- ☐ ☐ Peripheral Neuropathy
- ☐ ☐ Sciatica
- ☐ ☐ Tension-Type Headache
- ☐ ☐ Transient Ischemic Attacks (TIA)
- ☐ ☐ Trigeminal Neuralgia
- ☐ ☐ Other neurologic disease: _____

_____

YES NO

Head/Ear/Eyes/Nose Throat:
- ☐ ☐ Sinus Headache
- ☐ ☐ TMJ Disease
- ☐ ☐ Bell's Palsy
- ☐ ☐ Burning Mouth Syndrome
- ☐ ☐ Cataracts
- ☐ ☐ Head Trauma
- ☐ ☐ Laryngitis
- ☐ ☐ Lymphadenopathy (swollen glands)
- ☐ ☐ Meniere's Disease
- ☐ ☐ Macular Degeneration
- ☐ ☐ Sjogren's Syndrome
- ☐ ☐ Xerostomia

Gastrointestinal/Genitourinary:
- ☐ ☐ Crohn's Disease
- ☐ ☐ Frequent esophagitis
- ☐ ☐ Chronic gastritis
- ☐ ☐ Gastro-esophageal reflux (GERD)
- ☐ ☐ Hiatal Hernia
- ☐ ☐ Irritable bowel syndrome
- ☐ ☐ Malabsorption Syndrome
- ☐ ☐ Bladder or Urinary Infection

Respiratory:
- ☐ ☐ Bronchitis
- ☐ ☐ Obstructive Pulmonary Disease
- ☐ ☐ Obstructive Sleep Apnea
- ☐ ☐ Severe Snoring

Psychological:
- ☐ ☐ Phobias
- ☐ ☐ "Stressed out"
- ☐ ☐ Unusual anger
- ☐ ☐ Panic Disorder or Attacks
- ☐ ☐ Current Suicidal thoughts
- ☐ ☐ Suicide attempts in past
- ☐ ☐ Are you seeing a counselor/psychologist
- ☐ ☐ Are you seeing a psychiatrist
- ☐ ☐ Do you clench your jaw
- ☐ ☐ Do you hold facial/neck tension
- ☐ ☐ Do you or grind your teeth at night

Medications/Drugs/Alcohol:
- ☐ ☐ I have lots of side effects with medications
- ☐ ☐ I can not tolerate most medications
- ☐ ☐ I have (or had) drug or alcohol problems
- ☐ ☐ I use recreational drugs at times now (e.g. methamphetamine, marijuana, cocaine)

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Review of Symptoms: Do you have, or have you recently (within 1 year) had any of the following?

YES NO

Constitutional:
- ☐ ☐ recent weight change
- ☐ ☐ appetite changes
- ☐ ☐ problems going to sleep
- ☐ ☐ problems staying asleep
- ☐ ☐ fever
- ☐ ☐ chills
- ☐ ☐ malaise (excessive tiredness)
- ☐ ☐ recent trauma or infections

Endocrine/Hematologic/Lymphatic:
- ☐ ☐ excessive hunger
- ☐ ☐ excessive thirst
- ☐ ☐ spontaneous palpitations
- ☐ ☐ painful or discolored blood vessels
- ☐ ☐ painful or enlarged lymph glands
- ☐ ☐ excessive bleeding when cut
- ☐ ☐ spontaneous bleeding or anemia

Musculoskeletal:
- ☐ ☐ substantial muscle weakness
- ☐ ☐ difficulty walking due to balance
- ☐ ☐ fatigue or leg pain with walking
- ☐ ☐ joint swelling
- ☐ ☐ dislocation of any joints
- ☐ ☐ pain and swelling in any joint
- ☐ ☐ high joint flexibility or "double-jointedness"
- ☐ ☐ stiff neck with loss of neck motion
- ☐ ☐ chronic pain problems: _____

Neurological:
- ☐ ☐ recent memory loss
- ☐ ☐ unusual confusion
- ☐ ☐ loss of consciousness, black-outs or fainting
- ☐ ☐ reduced sensation or numbness
- ☐ ☐ spontaneous muscle spasms
- ☐ ☐ pain to light touch
- ☐ ☐ spinning sensations

Dermatologic:
- ☐ ☐ skin rash
- ☐ ☐ spontaneous bruising
- ☐ ☐ discoloration of skin
- ☐ ☐ blister or swelling on skin
- ☐ ☐ ulcer or growth on skin

YES NO

Head/Ears/Eyes/Nose/Throat:
- ☐ ☐ ear ringing
- ☐ ☐ hearing change or loss
- ☐ ☐ stuffy ears
- ☐ ☐ ear pain
- ☐ ☐ visual change or impairment
- ☐ ☐ eye pain
- ☐ ☐ nasal obstruction, sinusitis
- ☐ ☐ nasal or post-nasal discharge
- ☐ ☐ nose bleeding
- ☐ ☐ swallowing difficulty
- ☐ ☐ swollen neck/throat
- ☐ ☐ tender or enlarged neck/throat glands

Mouth/Stomatognathic:
- ☐ ☐ current oral sores/ulcers
- ☐ ☐ discoloration of oral tissues
- ☐ ☐ spontaneous mouth/gingival bleeding
- ☐ ☐ burning lips, tongue or mouth
- ☐ ☐ limited opening or jaw locking
- ☐ ☐ jaw joint noises
- ☐ ☐ pain in TMJ/ear or temples on function
- ☐ ☐ uncomfortable bite

Gastrointestinal:
- ☐ ☐ chronic diarrhea
- ☐ ☐ constipation
- ☐ ☐ stomach or abdominal pain
- ☐ ☐ frequent nausea or vomiting
- ☐ ☐ vomiting blood
- ☐ ☐ heartburn
- ☐ ☐ painful stomach
- ☐ ☐ bloody stools

Genitourinary
- ☐ ☐ painful urination
- ☐ ☐ difficulty or hesitancy with urinating

Respiratory:
- ☐ ☐ wet cough
- ☐ ☐ labored or painful cough
- ☐ ☐ difficult breathing (e.g. when laying flat)
- ☐ ☐ spitting up or coughing blood

Signing below means all of the preceding answers are true. If I have any change in my health status, or any change in my medicines, I will inform my dental health care provider at my next appointment.

Signature of patient (or Parent or Guardian as needed): _____ Date: _____

USC Faculty Signature (only after reviewing): _____ Date: _____

1206D-1025

USC PATIENT E-MAIL CONSENT FORM
To address the risks of using e-mail
If you choose to communicate with your Provider by e-mail you must review and consent to the conditions or instructions set forth below.

Email Address: _____

1. RISK OF USING E-MAIL

Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks.

a. E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to intended and unintended recipients.
b. E-mail senders can easily misaddress an e-mail.
c. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
d. Employers and online services have the right to archive and inspect e-mail transmitted through their systems.
e. E-mail can be intercepted, alerted, forwarded, or used without authorization or detection.
   1. Understand that the content of the e-mail may be monitored by USC to ensure appropriate use.
f. E-mail can be used to introduce viruses into computer systems.
g. E-mail can be used as evidence in court.
h. E-mails may not be secure, including at USC, and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. CONDITIONS FOR THE USE OF E-MAIL

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of e-mail information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a. **Although Provider will endeavor to read and respond promptly to an e-mail from the patient, Provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time sensitive matters.**
b. E-mail must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via e-mail.
c. **All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.**
d. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling.
e. Provider will not forward patient identifiable e-mails outside of USC healthcare providers without the patient's prior written consent, except as authorized or required by law.
f. The patient should not use e-mail for communication regarding sensitive medical information. According to California law, your provider may not communicate any lab results unless your e-mail correspondence is conducted through a secure server. Additionally, e-mail must never be used for results of testing related to HIV, sexually transmitted disease, hepatitis, drug abuse or presence of malignancy, or for alcohol abuse or mental health issues.
g. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
h. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:

a. Avoid use of his/her employer's computer.
b. Put the patient's name in the body of the e-mail. In the body of the message, include your name and your identification number (Medical Record Number) or your date of birth.
c. Key in the topic (e.g., medical question, billing question) in the subject line.
d. Inform Provider of changes in his/her e-mail address.
e. Acknowledge any e-mail received from the Provider.
f. Take precautions to preserve the confidentiality of the e-mail.

4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by e-mail. If I have any questions I may inquire with my treating physician or the USC Privacy Officer.

Patient Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

PATIENT E-MAIL CONSENT FORM

PATIENT ID

Herman Ostrow School of Dentistry of USC

The faculty, students and staff at the Herman Ostrow School of Dentistry of USC are committed to ensuring that you receive the highest quality of care and service.

We have developed a Patient's Bill of Rights and Responsibilities that reflects our standards for delivery of patient care. While we strive to provide you the highest standards of care, it is possible that you may feel that we have not achieved our goals. If you are dissatisfied with the care you are receiving, we hope that you will bring your concerns to our attention. We are also anxious to hear about positive experiences you have had and any individuals who were particularly competent, helpful, and courteous or who otherwise made your experience in our dental clinic a good one. We welcome any comments or suggestions you may have that will help us to serve you better.

Patient comment forms are available in all clinic offices for your use. Completed forms may be returned to any office or you can mail your comments to the Herman Ostrow School of Dentistry of USC Office of Quality Assurance, 925 West 34th Street, University Park MC 0641, Los Angeles, California 90089-0641.

We are please that you have selected the Herman Ostrow School of Dentistry of USC to be your dental care provider and look forward to serving your needs.

Douglas C. Solow, DDS, MBA
Associate Dean of Clinical Affairs

Nondiscrimination in Services Policy

Admissions, the provision of services, and referrals of patients shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age, or sex.

Services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery locations.

Any patient, parent and/or their guardian who believes they have been discriminated against may file a complaint of discrimination with: *USC's Office of Equity and Diversity*

USC's Office of Equity and Diversity
Phone Number (213) 740-5086

Herman Ostrow School of Dentistry of USC

Patient Bill of Rights and Responsibilities

The Herman Ostrow School of Dentistry of USC and its Affiliated Practices strives to provide a high quality of care and service to our patients. As a valued patient you have the following rights and responsibilities:

- ***You have a right*** to an appointment with your healthcare provider in a timely manner.
- ***You have a right*** to considerate, respectful, and confidential treatment.
- ***You have a right*** to have complete and current information about your condition.
- ***You have a right*** to know in advance the type and expected cost of treatment.
- ***You have a right*** to expect healthcare providers to use appropriate infection and sterilization controls.
- ***You have a right*** to an explanation of the prescribed treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment, and expected outcomes of these treatments, and be told, in language you can understand, the advantages and disadvantages of each.
- ***You have a right*** to ask your healthcare provider to explain all the treatment options regardless of your insurance benefit coverage or cost.
- ***You have a responsibility*** to keep your appointment, or reschedule in a timely manner.
- ***You have a responsibility*** to be considerate and respectful to others like your healthcare members and other patients.
- ***You have a responsibility*** to provide complete and current information about your condition.
- ***You have a responsibility*** to participate in your care and keep current on your cost of treatment and insurance coverage, if any.
- ***You have a responsibility*** to dress and present yourself appropriately.
- ***You have a responsibility***, as well as you are able, to participate in prescribed treatment, carefully weigh the consequences of accepting or refusing treatment, and appropriately discuss changes that might occur during your course of care.
- ***You have a responsibility*** to make reasonable decisions within yours and the school's limitations.

OCR NOTICE OF NONDISCRIMINATION

Source: HHS Office for Civil Rights

Herman Ostrow School of Dentistry of USC

complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Herman Ostrow School of Dentistry of USC

does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Herman Ostrow School of Dentistry of USC:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats)

• Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Douglas C. Solow DDS, MBA, Office of Clinical Affairs, (213) 740-1547

If you believe that Herman Ostrow School of Dentistry of USC

has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

USC Office of Equity and Diversity

3720 S. Flower Street, 2 nd floor

Credit Union Bldg., 200

Los Angeles, CA 90089-0704

Phone: (213) 740-5086, FAX (213) 740-5090

oed@usc.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, USC Office of Equity and Diversity is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services, 200
Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

Toll Free: 1-800-868-1019, 800-537-7697
(TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Grievance Procedure for Section 1557 Covered Practices with 15 or More Employees

It is the policy of the Herman Ostrow School of Dentistry of USC not to discriminate based on race, color, national origin, sex, age or disability. The Herman Ostrow School of Dentistry of USC
has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the USC Office of Equity and Diversity, 3720 S. Flower Street, 2nd floor, Credit Union Bldg. 200. Los Angeles, CA 90089-0704, Phone: (213) 740-5086, FAX (213) 740-5090, oed@usc.edu, who has been designated to coordinate the efforts of Herman Ostrow School of Dentistry of USC to comply with Section 1557.

Any person who believes someone has been subjected to discrimination based on race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Herman Ostrow School of Dentistry of USC to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Herman Ostrow School of Dentistry of USC relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the USC Office of Equity and Diversity within 15 days of

receiving the Section 1557 Coordinator's decision. The USC Office of Equity and Diversity shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination based on race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

The Herman Ostrow School of Dentistry of USC will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.