



# **STAKEHOLDER MEETING MATERIALS**

## **22 TEX. ADMIN. CODE 108.5**

### **April 1, 2016**

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## **NOTICE OF STAKEHOLDER MEETING**

### **22 TEX. ADMIN. CODE 108.5**

Staff of the Texas State Board of Dental Examiners will convene a stakeholder meeting to provide interested persons an opportunity to address board staff regarding 22 Texas Administrative Code (TAC) Chapter 108, Subchapter A, Rule 108.5, Patient Abandonment.

Rule 108.5 addresses a dentist's responsibilities to a patient upon a dentist's decision to terminate his or her treatment of a patient.

On January 26, 2016, board staff convened its first stakeholder meeting concerning Rule 108.5.

Staff will convene a second stakeholder meeting regarding this rule on:

**Friday, April 1, 2016, at 2:00 p.m.**

**Tower 2, Room 500**

**William P. Hobby Jr. Building**

**333 Guadalupe Street**

**Austin, Texas, 78701**

Additional materials will be distributed on or before March 18, 2016.

Stakeholders may also submit informal input by email to [stakeholders@tsbde.texas.gov](mailto:stakeholders@tsbde.texas.gov).

Should the Board vote to propose an amendment to Rule 108.5 in the future, the proposal would be published in the *Texas Register* for a formal public comment period.

Persons who have special communication or other accommodation needs who are planning to attend the stakeholder meeting should contact Cristabel Bodden, at [cbodden@tsbde.texas.gov](mailto:cbodden@tsbde.texas.gov) or (512) 305-9332. Arrangements should be made as far in advance as possible.

# Texas Administrative Code

<a href="#">TITLE 22</a>	EXAMINING BOARDS
<a href="#">PART 5</a>	STATE BOARD OF DENTAL EXAMINERS
<a href="#">CHAPTER 108</a>	PROFESSIONAL CONDUCT
<a href="#">SUBCHAPTER A</a>	PROFESSIONAL RESPONSIBILITY
RULE §108.5	Patient Abandonment

(a) A dentist, without reasonable cause, shall not abandon a dental patient. Once a dentist has undertaken a course of treatment, the dentist, absent reasonable cause, shall not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist. A dentist shall exercise the level of care necessary to prevent jeopardizing the patient's oral health during this process.

(b) Under this section, a dentist shall give a minimum of 30 days written notice of his/her intent to discontinue undertaken treatment. Notice shall be either hand-delivered to the patient or sent via certified mail, return receipt requested to the patient's last known address, with the dentist retaining a copy of the notice letter in the patient's file along with proof of service. Adequate notice shall include the following:

- (1) a short description of the patient's current status, including the patient's current diagnosis and a summary of the patient's current treatment plan;
- (2) a short description of the patient's present and future needs;
- (3) an explanation regarding the consequences of non-treatment;
- (4) a recommendation that the patient continue care with another dentist; and
- (5) a clear statement emphasizing that the dentist is available to provide any emergency treatment necessary to prevent patient harm during the 30-day period.

(c) A dentist shall remain reasonably available to render any emergency treatment necessary under (b) (5) of this section for up to 30 days from the date of such notice.

**Source Note:** The provisions of this §108.5 adopted to be effective February 20, 2001, 26 TexReg 1494; amended to be effective April 14, 2002, 27 TexReg 2826

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§ 108.5 Discontinuance of Treatment.

- a. A dentist abandons a patient when the dentist terminates active treatment of a patient without adequate notice.
- b. Active treatment means the patient has been treated by the dentist in the prior 24 months.
- c. A dentist may abandon a patient if the continuation of the treatment would pose a risk to a person's safety. A dentist may demonstrate other good cause for abandonment.
- d. The following notice is adequate: "I will no longer be able to treat you as my dental patient. Failure to continue your dental treatment could endanger your health. I recommend that you seek treatment from another dentist/specialist."

DRAFT

§ 108.5 Discontinuance of Treatment.

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- b. Under this section, a dentist shall provide reasonable notice of his/her intent to discontinue undertaken treatment. Notice may be delivered in the manner in which the dentist regularly communicates with the patient, including hand-delivery, email, or first class mail, with the dentist retaining a copy of the notice letter in the patient's file along with of the method of service.
- c. The following notice satisfies section (b) of this rule:

I will no longer be able to treat you at this dental practice. Failure to complete your dental treatment could cause xyz problems. I recommend that you seek continued treatment from another dentist/specialist.

- d. A dentist shall remain reasonably available to render any emergency treatment necessary under (b)(5) of this section for up to 30 days from the date of such notice.

DRAFT

§ 108.5 Discontinuance of Treatment.

a. Required Notification of Discontinuance of Practice. Except as provided for in subsection (e) of this section, when a dentist retires, terminates employment, or otherwise leaves a medical practice, he or she is responsible for:

1. ensuring that patients receive reasonable notification and are given the opportunity to obtain copies of their records or arrange for the transfer of their medical records to another dentist; and
2. notifying the board when they are terminating practice, retiring, or relocating, and therefore no longer available to patients, specifying who has custodianship of the records, and how the dental records may be obtained.
3. Employers of the departing dentist are not required to provide notification, however, the departing dentist remains responsible for providing notification consistent with this section.

b. Method of Notification.

1. Except as provided for in subsection (e) of this section, when a dentist retires, terminates employment, or otherwise leaves an office or place of business at which he or she practices dentistry, he or she shall provide notice to patients of when the dentist intends to terminate the practice, retire or relocate, and will no longer be available to patients, and offer patients the opportunity to obtain a copy of their dental records or have their records transferred.
2. Notification shall be accomplished by:
  - i. publishing notice in the newspaper of greatest general circulation in each county in which the dentist practices or practiced and in a local newspaper that serves the immediate practice area;
  - ii. placing written notice in the dentist's office; and
  - iii. sending written correspondence to patients seen in the last two years notifying them of discontinuance of practice.
3. A copy of the notice shall be submitted to the Board within 30 days from the date of termination, sale, or relocation of the practice.
4. Notices placed in the dentist's office shall be placed in a conspicuous location in or on the facade of the dentist's office, a sign, announcing the termination, sale, or relocation of the practice. The sign shall be placed at least thirty days prior to the termination, sale or relocation of practice and shall remain until the date of termination, sale or relocation.

c. Prohibition Against Interference.

1. Other licensed dentists remaining in the practice may not prevent the departing dentist from posting notice and the sign, unless the departing dentist is excepted from providing notice of his or her departure under subsection (f) of this section.
  2. A dentist, dentist group, or organization may not withhold information from a departing dentist that is necessary for notification of patients, unless the departing dentist is excepted from providing notice of his or her departure under subsection (e) of this section.
- d. Voluntary Surrender or Revocation of Dentist's License.
1. Except as provided for in subsection (e) of this section, dentists who have voluntarily surrendered their licenses or have had their licenses revoked by the board must notify their patients, consistent with subsection (b) of this section, within 30 days of the effective date of the voluntary surrender or revocation.
  2. Dentists who have voluntarily surrendered their licenses or have had their licenses revoked by the board must obtain a custodian for their dental records to be approved by the board within 30 days of the effective date of the voluntary surrender or revocation.
- e. Exceptions to Required Notification of Discontinuance of Practice.
1. A dentist is not required to provide notice of his or her discontinuance of practice to patients treated pursuant to a locum tenens position at a practice location, if the dentist was treating such patients during a period of no longer than six months at that location.
  2. For the purpose of this section, "locum tenens" is defined as a position in which a dentist is employed or contracted on a temporary or substitute basis to provide dental services.

# Texas Register

TITLE 22 EXAMINING BOARDS  
PART 9 TEXAS MEDICAL BOARD  
CHAPTER 165 MEDICAL RECORDS  
RULE §165.5 Transfer and Disposal of Medical Records  
ISSUE 01/17/2014  
ACTION Final/Adopted

[Preamble](#)

[Texas Admin Code Rule](#)

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(a)Required Notification of Discontinuance of Practice. Except as provided for in subsection (f) of this section, when a physician retires, terminates employment, or otherwise leaves a medical practice, he or she is responsible for:

(1)ensuring that patients receive reasonable notification and are given the opportunity to obtain copies of their records or arrange for the transfer of their medical records to another physician; and

(2)notifying the board when they are terminating practice, retiring, or relocating, and therefore no longer available to patients, specifying who has custodianship of the records, and how the medical records may be obtained.

(3)Employers of the departing physician as described in §165.1(b)(6) of this chapter are not required to provide notification, however, the departing physician remains responsible, for providing notification consistent with this section.

(b)Method of Notification.

(1)Except as provided for in subsection (f) of this section, when a physician retires, terminates employment, or otherwise leaves a medical practice, he or she shall provide notice to patients of when the physician intends to terminate the practice, retire or relocate, and will no longer be available to patients, and offer patients the opportunity to obtain a copy of their medical records or have their records transferred.

(2)Notification shall be accomplished by:

(A)publishing notice in the newspaper of greatest general circulation in each county in which the physician practices or practiced and in a local newspaper that serves the immediate practice area;

(B)placing written notice in the physician's office; and

(C)sending letters to patients seen in the last two years notifying them of discontinuance of practice.

(3)A copy of the notice shall be submitted to the Board within 30 days from the date of termination, sale, or relocation of the practice.

(4)Notices placed in the physician's office shall be placed in a conspicuous location in or on the facade

of the physician's office, a sign, announcing the termination, sale, or relocation of the practice. The sign shall be placed at least thirty days prior to the termination, sale or relocation of practice and shall remain until the date of termination, sale or relocation.

(c) Prohibition Against Interference.

(1) Other licensed physicians remaining in the practice may not prevent the departing physician from posting notice and the sign, unless the departing physician is excepted from providing notice of his or her departure under subsection (f) of this section.

(2) A physician, physician group, or organization described in §165.1(b)(6) of this title (relating to Medical Records) may not withhold information from a departing physician that is necessary for notification of patients, unless the departing physician is excepted from providing notice of his or her departure under subsection (f) of this section.

(d) Voluntary Surrender or Revocation of Physician's License.

(1) Except as provided for in subsection (f) of this section, physicians who have voluntarily surrendered their licenses or have had their licenses revoked by the board must notify their patients, consistent with subsection (b) of this section, within 30 days of the effective date of the voluntary surrender or revocation.

(2) Physicians who have voluntarily surrendered their licenses or have had their licenses revoked by the board must obtain a custodian for their medical records to be approved by the board within 30 days of the effective date of the voluntary surrender or revocation.

(e) Criminal Violation. A person who violates any provision of this chapter is subject to criminal penalties pursuant to §165.151 of the Act.

(f) Exceptions to Required Notification of Discontinuance of Practice.

(1) A physician is not required to provide notice of his or her discontinuation of practice to patients treated pursuant to a locum tenens position at a practice location, if the physician was treating such patients during a period of no longer than six months at that location.

(2) For the purpose of this section, "locum tenens" is defined as a position in which a physician is employed or contracted on a temporary or substitute basis to provide physician services.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 31, 2013

**TRD-201306161**

Mari Robinson, J.D.

Executive Director

Texas Medical Board

Effective date: January 20, 2014

# Texas Register

TITLE 22 EXAMINING BOARDS  
PART 18 TEXAS STATE BOARD OF PODIATRIC MEDICAL EXAMINERS  
CHAPTER 375 CONDUCT AND SCOPE OF PRACTICE  
RULE §375.3 General  
ISSUE 06/30/2006  
ACTION Final/Adopted

[Preamble](#)

[Texas Admin Code  
Rule](#)

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(a)The health and safety of patients shall be the first consideration of the podiatric physician. The principal objective to the podiatric profession is to render service to humanity. A podiatric physician shall continually strive to improve his medical knowledge and skill for the benefit of his patients and colleagues. The podiatric physician shall administer to patients in a professional manner and to the best of his ability. Secrets and personal information entrusted to him shall be held inviolate unless disclosure is necessary to protect the welfare of the individual or the community. A podiatric physician shall be temperate in all things in recognition that his knowledge and skill are essential to public health, welfare, and human life.

(b)A licensed podiatric physician shall conduct his practice on the highest plane of honesty, integrity, and fair dealing and shall not mislead his patients as to the gravity of such patient's podiatric medical needs. A podiatric physician shall not abandon a patient he has undertaken to treat. He may discontinue treatment after reasonable notice has been given to the patient by the podiatric physician of his intention to discontinue treatment and the patient has had a reasonable time to secure the services of another podiatric physician or all podiatric medical services actually begun have been completed and there is no contract or agreement to provide further treatment.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 15, 2006

**TRD-200603323**

Janie Alonzo

Staff Services Officer V

Texas State Board of Podiatric Medical Examiners

Effective date: July 5, 2006

Proposal publication date: January 6, 2006

For further information, please call: (512) 305-7000

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# Texas Administrative Code

[TITLE 22](#)

EXAMINING BOARDS

[PART 21](#)

TEXAS STATE BOARD OF EXAMINERS OF PSYCHOLOGISTS

[CHAPTER 465](#)

RULES OF PRACTICE

RULE §465.21

Termination of Services

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(a) Licensees do not abandon patients or clients.

(b) Withdrawal from a professional relationship in compliance with Board rules to avoid a prohibited dual relationship is not abandonment of a patient or client.

(c) Licensees terminate a professional relationship when it becomes reasonably clear that the patient or client no longer needs the service, is not benefiting or is being harmed by continued service.

(d) Prior to termination of a professional relationship for any reason, the licensee takes all reasonable steps to facilitate transfer of responsibility for the patient or client to a qualified service provider if necessary to prevent physical or emotional harm and, if not precluded by the patient or client's conduct, provides appropriate pre-termination counseling and referrals.

(e) Licensees who are required to interrupt services of a professional relationship for any reason shall make arrangements for provision of any services to all patients or clients required during the interruption.

(f) Termination of employment with agencies or organizations.

(1) When entering into employment or contractual relationships, licensees provide for orderly and appropriate resolution of responsibility for patient or client care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the patient or client.

(2) Licensees who are employed by an organization or agency to provide psychological services must, upon termination of that employment, work with the employer to facilitate access to records of all services provided by the licensee to patients or clients as otherwise required by Board rules and applicable law.

(3) Licensees who are employed by an organization or agency to provide psychological services must, upon termination of that employment, work with the employer to facilitate transfer of clients or patients who are continuing to receive services from the agency or organization to another qualified service provider.

(g) Termination of employment with public schools.

(1) A Licensed Specialist in School Psychology (LSSP) who is under contract as an employee of a public school to provide school psychological services must deliver to such public school a written resignation before terminating services or employment without cause. The resignation must be filed with the public school's board of trustees or designee not later than the 45th day before the first day of instruction of the following school year. A written resignation mailed by prepaid certified or registered mail to the president of the public school's board of trustees or designee at the post office address of the

public school is considered delivered at the time of mailing.

(2) A LSSP who is under contract as an employee of a public school may resign at any time if given written consent by the public school's board of trustees or designee or if such resignation is for cause.

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**Source Note:** The provisions of this §465.21 adopted to be effective June 3, 1999, 24 TexReg 4017; amended to be effective September 26, 2013, 38 TexReg 6207

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# Texas Administrative Code

[TITLE 22](#)

EXAMINING BOARDS

[PART 35](#)

TEXAS STATE BOARD OF EXAMINERS OF MARRIAGE AND FAMILY THERAPISTS

[CHAPTER 801](#)

LICENSURE AND REGULATION OF MARRIAGE AND FAMILY THERAPISTS

[SUBCHAPTER C](#)

GUIDELINES FOR PROFESSIONAL THERAPEUTIC SERVICES AND CODE OF ETHICS

RULE §801.44

Relationships with Clients

- (a) A licensee shall provide marriage and family therapy professional services only in the context of a professional relationship.
- (b) A licensee shall make known in writing to a prospective client the important aspects of the professional relationship, including but not limited to, the licensee's status as a Licensed Marriage and Family Therapist, including any probationary status or other restrictions placed on the licensee by the board, office procedures, after-hours coverage, fees, and arrangements for payment (which might affect the client's decision to enter into the relationship).
- (c) A licensee shall obtain an appropriate consent for treatment before providing professional services. A licensee shall make reasonable efforts to determine whether the conservatorship, guardianship, or parental rights of the client have been modified by a court. Prior to the commencement of therapy services to a minor client who is named in a custody agreement or court order, a licensee shall obtain and review a current copy of the custody agreement or court order in a suit affecting the parent-child relationship. A licensee shall maintain these documents in the client's record. When federal or state statutes provide an exemption to secure consent of a parent or guardian prior to providing services to a minor, a licensee shall follow the protocol set forth in such federal or state statutes.
- (d) A licensee shall make known in writing to a prospective client the confidential nature of the client's disclosures and the clinical record, including the legal limitations of the confidentiality of the mental health record and information.
- (e) No commission or rebate or any other form of remuneration shall be given or received by a licensee for the referral of clients for professional services. A licensee employed or under contract with a chemical dependency facility or a mental health facility, shall comply with the requirements in the Texas Health and Safety Code, §164.006, relating to soliciting and contracting with certain referral sources. Compliance with the Treatment Facilities Marketing Act, Texas Health and Safety Code, Chapter 164, shall not be considered as a violation of state law regarding illegal remuneration.
- (f) A licensee shall not exploit his/her position of trust with a client or former client.
- (g) A licensee shall not engage in activities that seek to meet the licensee's personal needs instead of the needs of the client.
- (h) A licensee shall not provide marriage and family therapy services to family members, personal friends, educational associates, business associates, or others whose welfare might be jeopardized by such a dual relationship.

- (i) A licensee shall set and maintain professional boundaries with clients and former clients.
- (j) A licensee may disclose confidential information to medical or law enforcement personnel if the licensee determines that there is a probability of imminent physical injury by the client to the client or others or there is a probability of immediate mental or emotional injury to the client.
- (k) In group therapy settings, the licensee shall take reasonable precautions to protect individuals from physical or emotional trauma resulting from interaction within the group.
- (l) A licensee shall make a reasonable effort to avoid non-therapeutic relationships with clients or former clients. A non-therapeutic relationship is an activity initiated by either the licensee or the client for the purposes of establishing a non-therapeutic relationship. It is the responsibility of the licensee to ensure the welfare of the client if a non-therapeutic relationship arises.
- (m) A licensee shall keep accurate records of therapeutic services to include, but not be limited to, dates of services, types of services, progress or case notes, and billing information for a minimum of 5 years for an adult client and 5 years beyond the age of 18 years of age for a minor.
- (n) Records created by licensees during the scope of their employment by educational institutions; by federal, state, or local government agencies; or political subdivisions or programs are not required to comply with the requirements of subsection (m) of this section.
- (o) A licensee shall bill clients or third parties for only those services actually rendered or as agreed to in writing.
- (p) A licensee shall terminate a professional relationship when it is reasonably clear that the client is not benefiting from it. Upon termination, if the client still requires mental health services, the licensee shall make reasonable efforts in writing to refer the client to appropriate services.
- (q) A licensee who engages in interactive therapy via the telephone or internet must provide the client with his/her license number and information on how to contact the board by telephone, electronic communication, or mail, and must adhere to all other provisions of this chapter.
- (r) A licensee shall only offer those services that are within his or her professional competency, and the services provided shall be within accepted professional standards of practice and appropriate to the needs of the client.
- (s) A licensee shall base all services on an assessment, evaluation, or diagnosis of the client.
- (t) A licensee shall evaluate a client's progress on a continuing basis to guide service delivery and will make use of supervision and consultation as indicated by the client's needs.
- (u) A licensee shall not promote or encourage the illegal use of alcohol or drugs by clients.
- (v) A licensee shall not knowingly offer or provide professional services to an individual concurrently receiving professional services from another mental health services provider except with that provider's knowledge. If a licensee learns of such concurrent professional services, the licensee shall take immediate and reasonable action to inform the other mental health services provider.
- (w) A licensee shall refrain from providing services while impaired by medication, drugs, or alcohol.
- (x) Upon termination of a relationship, if professional counseling or other marriage and family therapy

services are still necessary, the licensee shall take reasonable steps to facilitate the transfer to appropriate care.

(y) A licensee shall not aid or abet the unlicensed practice of marriage and family therapy services by a person required to be licensed under the Act. A licensee shall report to the board knowledge of any unlicensed practice.

(z) A licensee shall not enter into a non-professional relationship with a client's family member or any person having a personal or professional relationship with a client, if the licensee knows or reasonably should have known such a relationship could be detrimental to the client.

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**Source Note:** The provisions of this §801.44 adopted to be effective April 20, 1994, 19 TexReg 2386; amended to be effective April 11, 2001, 26 TexReg 2713; amended to be effective July 2, 2006, 31 TexReg 5111; amended to be effective May 18, 2008, 33 TexReg 3758; amended to be effective March 31, 2013, 38 TexReg 1982; amended to be effective November 23, 2014, 39 TexReg 9011

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# Texas Register

TITLE 40 SOCIAL SERVICES AND ASSISTANCE  
PART 12 TEXAS BOARD OF OCCUPATIONAL THERAPY EXAMINERS  
CHAPTER 374 DISCIPLINARY ACTIONS/DETRIMENTAL PRACTICE/COMPLAINT  
PROCESS/CODE OF ETHICS  
RULE Code of Ethics  
§374.4  
ISSUE 03/11/2016  
ACTION Final/Adopted

[Preamble](#)

[Texas Admin Code  
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(a)The Texas Board of Occupational Therapy Examiners' Code of Ethics is a public statement of the principles and related standards of conduct used in promoting and maintaining high standards of behavior in occupational therapy within the state of Texas. The Code of Ethics is a set of principles and standards that applies to occupational therapy practitioners. ("Practitioners" in this section are defined as those individuals licensed by this Board or applicants for licensure with this Board.)

(b)Principles and Related Standards of Conduct:

[Attached Graphic](#)

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 29, 2016

**TRD-201600964**

John P. Maline

Executive Director

Texas Board of Occupational Therapy Examiners

Effective date: April 1, 2016

Proposal publication date: December 4, 2015

For further information, please call: (512) 305-6900

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Figure: 40 TAC §374.4(b)

### Principles and Related Standards of Conduct

The principles and related standards of conduct that follow are from the Occupational Therapy Code of Ethics (2015), by the American Occupational Therapy Association, as published in *American Journal of Occupational Therapy*, 69, 6913410030p1-6913410030p8. <http://dx.doi.org/10.5014/ajot.2015.696S03>.

### **Beneficence**

#### **Principle 1. Occupational therapy personnel shall demonstrate a concern for the well-being and safety of the recipients of their services.**

Beneficence includes all forms of action intended to benefit other persons. The term *beneficence* connotes acts of mercy, kindness, and charity (Beauchamp & Childress, 2013). Beneficence requires taking action by helping others, in other words, by promoting good, by preventing harm, and by removing harm. Examples of beneficence include protecting and defending the rights of others, preventing harm from occurring to others, removing conditions that will cause harm to others, helping persons with disabilities, and rescuing persons in danger (Beauchamp & Childress, 2013).

### **Related Standards of Conduct**

#### **Occupational therapy personnel shall**

- A. Provide appropriate evaluation and a plan of intervention for recipients of occupational therapy services specific to their needs.
- B. Reevaluate and reassess recipients of service in a timely manner to determine whether goals are being achieved and whether intervention plans should be revised.
- C. Use, to the extent possible, evaluation, planning, intervention techniques, assessments, and therapeutic equipment that are evidence based, current, and within the recognized scope of occupational therapy practice.
- D. Ensure that all duties delegated to other occupational therapy personnel are congruent with credentials, qualifications, experience, competency, and scope of practice with respect to service delivery, supervision, fieldwork education, and research.
- E. Provide occupational therapy services, including education and training, that are within each practitioner's level of competence and scope of practice.
- F. Take steps (e.g., continuing education, research, supervision, training) to ensure proficiency, use careful judgment, and weigh potential for harm when generally recognized standards do not exist in emerging technology or areas of practice.

- G. Maintain competency by ongoing participation in education relevant to one's practice area.
- H. Terminate occupational therapy services in collaboration with the service recipient or responsible party when the services are no longer beneficial.
- I. Refer to other providers when indicated by the needs of the client.
- J. Conduct and disseminate research in accordance with currently accepted ethical guidelines and standards for the protection of research participants, including determination of potential risks and benefits.

## **Nonmaleficence**

### **Principle 2. Occupational therapy personnel shall refrain from actions that cause harm.**

*Nonmaleficence* “obligates us to abstain from causing harm to others” (Beauchamp & Childress, 2013, p. 150). The Principle of *Nonmaleficence* also includes an obligation to not impose risks of harm even if the potential risk is without malicious or harmful intent. This Principle often is examined under the context of due care. The standard of *due care* “requires that the goals pursued justify the risks that must be imposed to achieve those goals” (Beauchamp & Childress, 2013, p. 154). For example, in occupational therapy practice, this standard applies to situations in which the client might feel pain from a treatment intervention; however, the acute pain is justified by potential longitudinal, evidence-based benefits of the treatment.

## **Related Standards of Conduct**

### **Occupational therapy personnel shall**

- A. Avoid inflicting harm or injury to recipients of occupational therapy services, students, research participants, or employees.
- B. Avoid abandoning the service recipient by facilitating appropriate transitions when unable to provide services for any reason.
- C. Recognize and take appropriate action to remedy personal problems and limitations that might cause harm to recipients of service, colleagues, students, research participants, or others.
- D. Avoid any undue influences that may impair practice and compromise the ability to safely and competently provide occupational therapy services, education, or research.
- E. Address impaired practice and when necessary report to the appropriate authorities.
- F. Avoid dual relationships, conflicts of interest, and situations in which a practitioner, educator, student, researcher, or employer is unable to maintain clear professional boundaries or objectivity.
- G. Avoid engaging in sexual activity with a recipient of service, including the client's family or significant other, student, research participant, or employee, while a professional relationship exists.

- H. Avoid compromising rights or well-being of others based on arbitrary directives (e.g., unrealistic productivity expectations, falsification of documentation, inaccurate coding) by exercising professional judgment and critical analysis.
- I. Avoid exploiting any relationship established as an occupational therapy clinician, educator, or researcher to further one's own physical, emotional, financial, political, or business interests at the expense of recipients of services, students, research participants, employees, or colleagues.
- J. Avoid bartering for services when there is the potential for exploitation and conflict of interest.

## **Autonomy**

### **Principle 3. Occupational therapy personnel shall respect the right of the individual to self-determination, privacy, confidentiality, and consent.**

The Principle of *Autonomy* expresses the concept that practitioners have a duty to treat the client according to the client's desires, within the bounds of accepted standards of care, and to protect the client's confidential information. Often, respect for Autonomy is referred to as the *self-determination principle*. However, respecting a person's autonomy goes beyond acknowledging an individual as a mere agent and also acknowledges a person's right "to hold views, to make choices, and to take actions based on [his or her] values and beliefs" (Beauchamp & Childress, 2013, p. 106). Individuals have the right to make a determination regarding care decisions that directly affect their lives. In the event that a person lacks decision-making capacity, his or her autonomy should be respected through involvement of an authorized agent or surrogate decision maker.

## **Related Standards of Conduct**

### **Occupational therapy personnel shall**

- A. Respect and honor the expressed wishes of recipients of service.
- B. Fully disclose the benefits, risks, and potential outcomes of any intervention; the personnel who will be providing the intervention; and any reasonable alternatives to the proposed intervention.
- C. Obtain consent after disclosing appropriate information and answering any questions posed by the recipient of service or research participant to ensure voluntariness.
- D. Establish a collaborative relationship with recipients of service and relevant stakeholders, to promote shared decision making.
- E. Respect the client's right to refuse occupational therapy services temporarily or permanently, even when that refusal has potential to result in poor outcomes.
- F. Refrain from threatening, coercing, or deceiving clients to promote compliance with occupational therapy recommendations.
- G. Respect a research participant's right to withdraw from a research study without penalty.

- H. Maintain the confidentiality of all verbal, written, electronic, augmentative, and nonverbal communications, in compliance with applicable laws, including all aspects of privacy laws and exceptions thereto (e.g., Health Insurance Portability and Accountability Act, Family Educational Rights and Privacy Act).
- I. Display responsible conduct and discretion when engaging in social networking, including but not limited to refraining from posting protected health information.
- J. Facilitate comprehension and address barriers to communication (e.g., aphasia; differences in language, literacy, culture) with the recipient of service (or responsible party), student, or research participant.

## **Justice**

### **Principle 4. Occupational therapy personnel shall promote fairness and objectivity in the provision of occupational therapy services.**

The Principle of *Justice* relates to the fair, equitable, and appropriate treatment of persons (Beauchamp & Childress, 2013). Occupational therapy personnel should relate in a respectful, fair, and impartial manner to individuals and groups with whom they interact. They should also respect the applicable laws and standards related to their area of practice. Justice requires the impartial consideration and consistent following of rules to generate unbiased decisions and promote fairness. As occupational therapy personnel, we work to uphold a society in which all individuals have an equitable opportunity to achieve occupational engagement as an essential component of their life.

## **Related Standards of Conduct**

### **Occupational therapy personnel shall**

- A. Respond to requests for occupational therapy services (e.g., a referral) in a timely manner as determined by law, regulation, or policy.
- B. Assist those in need of occupational therapy services to secure access through available means.
- C. Address barriers in access to occupational therapy services by offering or referring clients to financial aid, charity care, or pro bono services within the parameters of organizational policies.
- D. Advocate for changes to systems and policies that are discriminatory or unfairly limit or prevent access to occupational therapy services.
- E. Maintain awareness of current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy.
- F. Inform employers, employees, colleagues, students, and researchers of applicable policies, laws, and Official Documents.
- G. Hold requisite credentials for the occupational therapy services they provide in academic, research, physical, or virtual work settings.

- H. Provide appropriate supervision in accordance with AOTA Official Documents and relevant laws, regulations, policies, procedures, standards, and guidelines.
- I. Obtain all necessary approvals prior to initiating research activities.
- J. Refrain from accepting gifts that would unduly influence the therapeutic relationship or have the potential to blur professional boundaries, and adhere to employer policies when offered gifts.
- K. Report to appropriate authorities any acts in practice, education, and research that are unethical or illegal.
- L. Collaborate with employers to formulate policies and procedures in compliance with legal, regulatory, and ethical standards and work to resolve any conflicts or inconsistencies.
- M. Bill and collect fees legally and justly in a manner that is fair, reasonable, and commensurate with services delivered.
- N. Ensure compliance with relevant laws and promote transparency when participating in a business arrangement as owner, stockholder, partner, or employee.
- O. Ensure that documentation for reimbursement purposes is done in accordance with applicable laws, guidelines, and regulations.
- P. Refrain from participating in any action resulting in unauthorized access to educational content or exams (including but not limited to sharing test questions, unauthorized use of or access to content or codes, or selling access or authorization codes).

## **Veracity**

### **Principle 5. Occupational therapy personnel shall provide comprehensive, accurate, and objective information when representing the profession.**

Veracity is based on the virtues of truthfulness, candor, and honesty. The Principle of *Veracity* refers to comprehensive, accurate, and objective transmission of information and includes fostering understanding of such information (Beauchamp & Childress, 2013). Veracity is based on respect owed to others, including but not limited to recipients of service, colleagues, students, researchers, and research participants.

In communicating with others, occupational therapy personnel implicitly promise to be truthful and not deceptive. When entering into a therapeutic or research relationship, the recipient of service or research participant has a right to accurate information. In addition, transmission of information is incomplete without also ensuring that the recipient or participant understands the information provided.

Concepts of veracity must be carefully balanced with other potentially competing ethical principles, cultural beliefs, and organizational policies. Veracity ultimately is valued as a means to establish trust and strengthen professional relationships. Therefore, adherence to the Principle of Veracity also requires thoughtful analysis of how full disclosure of information may affect outcomes.

## **Related Standards of Conduct**

### **Occupational therapy personnel shall**

- A. Represent credentials, qualifications, education, experience, training, roles, duties, competence, contributions, and findings accurately in all forms of communication.
- B. Refrain from using or participating in the use of any form of communication that contains false, fraudulent, deceptive, misleading, or unfair statements or claims.
- C. Record and report in an accurate and timely manner and in accordance with applicable regulations all information related to professional or academic documentation and activities.
- D. Identify and fully disclose to all appropriate persons errors or adverse events that compromise the safety of service recipients.
- E. Ensure that all marketing and advertising are truthful, accurate, and carefully presented to avoid misleading recipients of service, research participants, or the public.
- F. Describe the type and duration of occupational therapy services accurately in professional contracts, including the duties and responsibilities of all involved parties.
- G. Be honest, fair, accurate, respectful, and timely in gathering and reporting fact-based information regarding employee job performance and student performance.
- H. Give credit and recognition when using the ideas and work of others in written, oral, or electronic media (i.e., do not plagiarize).
- I. Provide students with access to accurate information regarding educational requirements and academic policies and procedures relative to the occupational therapy program or educational institution.
- J. Maintain privacy and truthfulness when utilizing telecommunication in delivery of occupational therapy services.

## **Fidelity**

### **Principle 6. Occupational therapy personnel shall treat clients, colleagues, and other professionals with respect, fairness, discretion, and integrity.**

The Principle of *Fidelity* comes from the Latin root *fidelis*, meaning loyal. *Fidelity* refers to the duty one has to keep a commitment once it is made (Veatch, Haddad, & English, 2010). In the health professions, this commitment refers to promises made between a provider and a client or patient based on an expectation of loyalty, staying with the patient in a time of need, and compliance with a code of ethics. These promises can be implied or explicit. The duty to disclose information that is potentially meaningful in making decisions is one obligation of the moral contract between provider and client or patient (Veatch et al., 2010).

Whereas respecting Fidelity requires occupational therapy personnel to meet the client's reasonable expectations, the Principle also addresses maintaining respectful collegial and organizational relationships (Purtilo & Doherty, 2011). Professional relationships are greatly

influenced by the complexity of the environment in which occupational therapy personnel work. Practitioners, educators, and researchers alike must consistently balance their duties to service recipients, students, research participants, and other professionals as well as to organizations that may influence decision making and professional practice.

## **Related Standards of Conduct**

### **Occupational therapy personnel shall**

- A. Preserve, respect, and safeguard private information about employees, colleagues, and students unless otherwise mandated or permitted by relevant laws.
- B. Address incompetent, disruptive, unethical, illegal, or impaired practice that jeopardizes the safety or well-being of others and team effectiveness.
- C. Avoid conflicts of interest or conflicts of commitment in employment, volunteer roles, or research.
- D. Avoid using one's position (employee or volunteer) or knowledge gained from that position in such a manner as to give rise to real or perceived conflict of interest among the person, the employer, other AOTA members, or other organizations.
- E. Be diligent stewards of human, financial, and material resources of their employers, and refrain from exploiting these resources for personal gain.
- F. Refrain from verbal, physical, emotional, or sexual harassment of peers or colleagues.
- G. Refrain from communication that is derogatory, intimidating, or disrespectful and that unduly discourages others from participating in professional dialogue.
- H. Promote collaborative actions and communication as a member of interprofessional teams to facilitate quality care and safety for clients.
- I. Respect the practices, competencies, roles, and responsibilities of their own and other professions to promote a collaborative environment reflective of interprofessional teams.
- J. Use conflict resolution and internal and alternative dispute resolution resources as needed to resolve organizational and interpersonal conflicts, as well as perceived institutional ethics violations.
- K. Abide by policies, procedures, and protocols when serving or acting on behalf of a professional organization or employer to fully and accurately represent the organization's official and authorized positions.
- L. Refrain from actions that reduce the public's trust in occupational therapy.
- M. Self-identify when personal, cultural, or religious values preclude, or are anticipated to negatively affect, the professional relationship or provision of services, while adhering to organizational policies when requesting an exemption from service to an individual or group on the basis of conflict of conscience.

# Texas Administrative Code

TITLE 22

EXAMINING BOARDS

PART 24

TEXAS BOARD OF VETERINARY MEDICAL EXAMINERS

CHAPTER 573

RULES OF PROFESSIONAL CONDUCT

SUBCHAPTER C

RESPONSIBILITIES TO CLIENTS

RULE §573.20

Responsibility for Acceptance of Medical Care

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(a) The decision to accept an animal as a patient is at the sole discretion of a veterinarian. The veterinarian is responsible for determining the diagnosis and course of treatment for an animal that has been accepted as a patient and for advising the client as to the diagnosis and treatment to be provided.

(b) For purposes of establishing a veterinarian-client-patient relationship under §801.351 of the Veterinary Licensing Act, Texas Occupations Code, a veterinarian can obtain sufficient knowledge of an animal by making medically appropriate and timely visits to the premises on which the animal is kept only if the animal is a member of a herd.

(c) A veterinarian must inform a client when:

(1) the client has specifically requested that the veterinarian diagnose and/or treat the client's animal; and

(2) the veterinarian reasonably believes there is a likelihood or possibility that another veterinarian may perform some or all of the diagnosis and/or treatment of the patient.

(d) Once a veterinarian-client-patient relationship has been established, a veterinarian may discontinue treatment:

(1) at the request of the client;

(2) after the veterinarian substantially completes the treatment or diagnostics prescribed;

(3) upon referral to another veterinarian; or

(4) after notice to the client providing a reasonable period for the client to secure the services of another veterinarian.

(e) Once a veterinarian establishes a veterinarian-client-patient relationship and prescribes medication(s), another Texas licensed veterinarian within the same clinic or hospital who has access to the patient's current medical records may refill that same prescription(s) without a veterinary-client-patient relationship.

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**Source Note:** The provisions of this §573.20 adopted to be effective June 14, 2012, 37 TexReg 4229; amended to be effective August 29, 2013, 38 TexReg 5487; amended to be effective May 4, 2015, 40 TexReg 2418

# CDA Code of Ethics

Adopted by the California Dental Association  
House of Delegates, November 2012

**California Dental Association**  
1201 K Street, Sacramento, CA 95814  
800.232.7645 cda.org



## Introduction

The privilege of being a dentist comes with a responsibility to society and to fellow members of the profession to conduct one's professional activities in a highly ethical manner. California Dental Association (CDA) members agree to abide by the tenets embodied in the American Dental Association (ADA) Principles of Ethics and Code of Professional Conduct (ADA Code) and the CDA Code of Ethics. The CDA Code of Ethics, in general, pertains to 1) service to the public, 2) conduct in a dental office and between dental practitioners, and 3) how dental practices and services are promoted. By following the Code of Ethics, dentists build public trust and maintain high ethical standards for the benefit of all.

## Preamble

The CDA Code of Ethics consists of values and behavioral principles that serve as guidelines for the ethical practice of dentistry. The CDA Judicial Council may, from time to time, issue advisory opinions setting forth the council's interpretations of the principles set forth in this code. Such advisory opinions are meant to be consultative in nature and are designed to aid in the resolution of specific ethical dilemmas. They are not binding interpretations and do not become a part of this code, but they may be considered as persuasive by the trial body and any disciplinary proceedings under the CDA Bylaws should a dentist be charged with a violation of the ADA Code or the CDA Code of Ethics.

## Ethical Principles

As health care professionals, dentists assume publicly-entrusted responsibilities founded on the principle of non-maleficence—first do no harm. Some of the many characteristics of being an ethical dental professional are presented in the American College of Dentists' Core Values and are hereby adopted by the California Dental Association as its core ethical principles:

**Autonomy:** Patients have the right to determine what should be done with their own bodies. Because patients are moral entities they are capable of autonomous decision-making. Respect for patient autonomy affirms this dynamic in the doctor-patient relationship and forms the foundation for informed consent, for protecting patient confidentiality, and for upholding veracity. The patient's right to self-determination is not, however, absolute. The dentist must also weigh benefits and harms and inform the patient of contemporary standards of oral health care.

**Beneficence:** Beneficence, often cited as a fundamental principle of ethics, is the obligation to benefit others or to seek their good. While balancing harms and benefits, the dentist seeks to minimize harms and maximize benefits for the patient. The dentist refrains from harming the patient by referring to those with specialized expertise when the dentist's own skills are insufficient.

**Compassion:** Compassion requires caring and the ability to identify with the patient's overall well-being. Relieving pain and suffering is a common attribute of dental practice. Acts of kindness and a sympathetic ear for the patient are all qualities of a caring, compassionate dentist.

**Competence:** The competent dentist is able to diagnose and treat the patient's oral health needs and to refer when it is in the patient's best interest. Maintaining competence requires continual self-assessment about the outcome of patient care and involves a commitment to lifelong learning. Competence is the just expectation of the patient.

**Integrity:** Integrity requires the dentist to behave with honor and decency. The dentist who practices with a sense of integrity affirms the core values and recognizes when words, actions or intentions are in conflict with one's values and conscience. Professional integrity commits the dentist to upholding the professions' Codes of Ethics and to safeguarding, influencing and promoting the highest professional standards.

**Justice:** Justice is often associated with fairness or giving to each his or her own due. Issues of fairness are pervasive in dental practice and range from elemental procedural issues such as who shall receive treatment first, to complex questions of who shall receive treatment at all. The just dentist must be aware of these complexities when balancing the distribution of benefits and burdens in practice.

**Professionalism:** Self-governance is a hallmark of a profession and dentistry will thrive as long as its members are committed to actively support and promote the profession and its service to the public. The commitment to promoting oral health initiatives and protecting the public requires that the profession work together for the collective best interest of society.

**Tolerance:** Dentists are challenged to practice within an increasingly complex cultural and ethnically diverse community. Conventional attitudes regarding pain, appropriate function, and esthetics may be confounded by these differences. Tolerance to diversity requires dentists to recognize that these differences exist and challenges dentists to understand how these differences may affect patient choices and treatment.

**Veracity:** Veracity, often known as honesty or truth telling, is the bedrock of a trusting doctor-patient relationship. The dentist relies on the honesty of the patient to gather the facts necessary to form a proper diagnosis. The patient relies on the dentist to be truthful so that truly informed decision-making can occur. Honesty in dealing with the public, colleagues and self are equally important.

## Behavioral Principles

### Section 1. Service to the Public

Service to the public is the primary obligation of the dentist as a professional person. Service to the public includes the delivery of quality, competent, and timely care within the bounds of the clinical circumstances presented by the patient.

#### 1.A. Professional Esteem

While serving the public, a dentist has the obligation to act in a manner that maintains or elevates the esteem of the profession.

#### 1.B. Accepting Patients Into the Dental Practice

In serving the public, a dentist may exercise reasonable discretion in accepting patients into the dental practice. However, in keeping with the core value of justice, it is unethical for a dentist to refuse to accept a patient into the practice, deny dental service to a patient, or otherwise discriminate against a patient because of the patient's gender, sexual, racial, religious, or ethnic characteristics.

##### Advisory Opinions:

1.B.1. Patient Abandonment: Once a dentist has undertaken a course of treatment, the dentist should not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist. Care should be taken that the patient's oral health is not jeopardized in the process.

1.B.2. Notice of Provider Relocation: Patients treated by a dentist who leaves a dental practice have the right to be informed of the dentist's new contact information. It is unethical to withhold this information, if known, upon the request of a patient or to provide misleading information to patients. If the responsibility for notifying the patients falls to the departing dentist rather than the dental practice, the practice should not interfere with the discharge of these duties by withholding patient lists or other necessary information.

#### 1.C. Standards of Care

Wherever "standards of care" or "quality services" are undefined by law, such standards or services shall be defined by the California Dental Association or such agency as designated by the association. It is unethical for a dentist to render, or cause to be rendered, substandard care.

#### 1.D. Informed Consent

Fully informed consent is essential to the ethical practice of dentistry and reflects the patient's right of self-decision. Except as exempted by state law, a dentist has the obligation to obtain the fully informed consent of the patient or the patient's legal guardian prior to treatment, or the use of any identifiable artifacts (such as photographs,

X-rays, study models, etc.) for any purpose other than treatment. Informed consent is also required when using a human subject for research.

##### Advisory Opinions:

1.D.1. Explanation of Treatment: A dentist has the obligation to fully explain proposed treatment, reasonable alternatives, and the risks of not performing treatment to the patient. The dentist shall explain treatment in a manner that is accurate, easily understood, and allows patients to be involved in decisions affecting their oral health or their participation in a research project.

1.D.2. Reporting Abuse: When a dentist suspects abuse, the dentist is not legally required to obtain informed consent prior to taking photographs, impressions or x-rays on a minor or dependent adult.

#### 1.E. Patient Confidentiality

Dentists are obliged to safeguard the confidentiality of patient records. Dentists shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Upon request of a patient or another dental practitioner, dentists shall provide any information in accordance with applicable law that will be beneficial for the future treatment of that patient.

#### 1.F. Obligation to Inform

A dentist has the obligation to inform patients of their present oral health status.

##### Advisory Opinion:

1.F.1 It is the duty of a dentist to report instances of gross and/or continual faulty treatment. When informing patients of the status of their oral health, the dentist shall exercise care that the comments made are justifiable. This would include finding out from the previous treating dentist under what circumstances and conditions the treatment was performed. A difference of opinion as to preferred treatment shall not be communicated to the patient in a disparaging manner which implies mistreatment.

#### 1.G. Health Education of the Public

A dentist may participate in a program of health education of the public, involving such media as the press, radio, television, and lecture, provided that such programs are in keeping with the dignity of the profession.

##### Advisory Opinion:

1.G.1 Solicitation of Children: Solicitation of children on any private or public school grounds by the use of dental health programs (e.g., dental screening, mouth guards, sealants, etc.) for the purpose of generating referrals or for the financial benefit of the dentists participating in such programs is deemed not to elevate the esteem

of the dental profession. For purposes of this advisory opinion, solicitation includes, but is not limited to, dissemination of business cards or any other materials intended to promote the dentist's practice.

## Section 2. Government of a Profession

Every profession receives from society the right and obligation to regulate itself, to determine and judge its own members. Such regulation is achieved largely through the influence of the professional societies, and a dentist has the dual obligation of becoming part of a professional society and of observing its rules of ethics.

### 2A. False Statements

It is unethical for a dentist to make a statement in any document filed with the California Dental Association, its component societies, or the American Dental Association, which is fraudulent or false in a material respect, or which omits to disclose any material fact or matter. For the purpose of this section, the word "material" means "not insubstantial" or "of significance" with respect to reasons for which the document is filed.

## Section 3. Cooperation with Duly Constituted Committees

A dentist has the obligation to comply with the reasonable requests of a duly constituted committee, council or other body of the component society or of this association necessary or convenient to enable such a body to perform its functions and to abide by the decisions of such body.

## Section 4. Violation of State and Federal Laws

A dentist has the obligation to comply with all state and federal laws and regulations. It is unethical for a dentist to violate any law of the state of California relating to the practice of dentistry or to engage in activity for which the dentist may be reprimanded, disciplined, or sentenced by final action of any court or other authority of competent jurisdiction, when such action reflects unfavorably on dentists or the dental profession. It is also unethical for a dentist to engage in unprofessional conduct as it is defined by the Dental Practice Act.

## Section 5. Continuing Education

The right of dentists to professional status rests in the knowledge, skill and experience with which they serve their patients and society. Dentists have the obligation to advance their knowledge and keep their skills freshened by continuing education throughout their professional lives.

## Section 6. Representations and Claims

In order to properly serve the public, dentists have the obligation to represent themselves in a manner that contributes to the esteem of the profession.

## 6A. False and Misleading Advertising and Solicitations

It is unethical for a dentist to mislead a patient or misrepresent in any material respect either directly or indirectly the dentist's identity, training, competence, services, or fees. Likewise, it is unethical for a dentist to advertise or solicit patients in any form of communication in a manner that is false or misleading in any material respect.

Advisory Opinions:

6.A.1. False Advertising: A dentist shall not disseminate, permit or cause to be disseminated, or participate in the benefits from any form of advertising containing a statement or claim which is false or misleading in any material respect, for the purpose of, directly or indirectly, soliciting patients or inducing the rendering of dental services.

A statement or claim is false or misleading when it:

- Contains a material misrepresentation of fact;
- Is materially misleading because the statement as a whole makes only a partial disclosure of relevant facts; or
- Is intended or is likely to create false or unjustified expectations of favorable results.

6.A.2. Publicity: A dentist who compensates or gives anything of value to a representative of the press, radio, television or other communication medium in anticipation of, or in return for, professional publicity must make known the fact of such compensation in such publicity.

6.A.3. Public Statements: A dentist shall not issue or cause to be issued through any medium, a public statement expressing or implying official sanction of the ADA, CDA, or any of its component societies, without due consent of the governing body of said organization. Upon receiving such authorization, the dentist shall ascertain that any public statement is scientifically correct and complies with the Code of Ethics.

6.A.4. Subjective statements about the quality of dental services can raise ethical concerns. In particular, statements of opinion may be misleading if they are not honestly held, if they misrepresent the qualifications of the holder, or the basis of the opinion, or if the patient reasonably interprets them as implied statements of fact. Such statements will be evaluated on a case by case basis, considering how patients are likely to respond to the impression made by the advertisement as a whole. The fundamental issue is whether the advertisement, taken as a whole, is false or misleading in a material respect.



## 6B. Professional Titles and Degrees

Dentists may use the degrees conferred upon them by diploma from recognized dental colleges or schools legally empowered to confer the same, the letters "D.D.S." as permitted by state law, and/or the titles, "Doctor" or "Dentist" and any additional advanced academic degrees earned in health service areas. It is unethical for a dentist to use a title or degree in connection with the promotion of any dental or other commercial endeavor when such usage is false or misleading in any material respect.

Advisory Opinions:

6.B.1. Volunteer Position Titles and Experience: A dentist using volunteer position titles and association and/or component society connected experience in any commercial endeavor may be making a representation which is false or misleading in a material respect. Such use of volunteer position titles and association and/or component society connected experience may be misleading because of the likelihood that it will suggest that the dentist using such is claiming superior skills. However, when such usage does not conflict with state law, volunteer position titles and association and/or component society connected experience may be indicated in scientific papers and curriculum vitae which are not used for any commercial endeavor. In any review by the council of the use of volunteer position titles and association and/or component society connected experience, the council will apply the standard of whether the use of such is false or misleading in a material respect.

6.B.2. Additional Advanced Academic Degrees: The phrase "any additional advanced academic degrees earned in health service areas" is interpreted to mean only those degrees that are earned after a dentist graduates from dental or medical school. Use of a degree earned prior thereto may be misleading in a material respect because of the likelihood that it will indicate to the public the attainment of specialty status or advanced dental education. A dentist may list degrees only in the order received. A certificate or license is not a degree and shall not be listed with professional titles or degrees.

6.B.3. Letter Abbreviations: A dentist may append either the letters "D.D.S." as permitted by state law, or the letter abbreviation(s) representing the degree(s) conferred upon the dentist by a recognized dental college or school legally empowered to confer the same, when indicating successful completion of a dental educational program. The simultaneous use of these abbreviations, however, may be making a representation which is false or misleading in a material respect as it implies completion of an increased level of dental education. In any review by the council of the use of letter abbreviations, the council will apply the standard of whether the use of such is false or misleading in a material respect.

## 6C. Name of Practice

As the name under which a dentist conducts a dental practice may be a factor in the selection process of the patient, it is unethical for a dentist to use a trade name or an assumed name that is false or misleading in any material respect. Use of the name of a dentist no longer actively associated with the practice may be continued for a period not to exceed one year.

## Section 7: Billing Practices

A dentist has the obligation to submit any billing for services rendered or to be rendered in a manner which is not fraudulent, deceitful, or misleading.

Advisory Opinions:

7.A.1. Third Party<sup>1</sup> Benefits: A dentist shall avoid any representation that causes patients to believe the dentist is a provider for the patient's third party payer if, in fact, the dentist is not.

7.A.2. Waiver of Copayment: A dentist who accepts a third party payment under a copayment plan as payment in full, without disclosing to the third party payer that the patient's payment portion will not be collected, may be engaged in overbilling. The essence of this ethical impropriety is deception and misrepresentation; an overbilling dentist makes it appear to the third party<sup>1</sup> payer that the charge to the patient for the services rendered is higher than it actually is.

7.A.3. Billing For Services Not Rendered: A dentist shall avoid billing for services not rendered. If payment has been received for a service that is ultimately never rendered, the dentist shall arrange to refund any overpayment immediately.

## Section 8. Emergency Service

A dentist has the obligation to make reasonable arrangements for the emergency care of his or her patients of record. A dentist has the obligation, when consulted in an emergency by a patient not of record, to make reasonable arrangements for emergency care of that patient.

Advisory Opinion:

8.A.1. Continuity of Care: In the interest of preserving the patient's continuity of care, a dentist who treats a patient not of record shall recommend to the patient to continue treatment with the original treating dentist unless the patient expressly reveals a different preference.

## Section 9. Consultation and Referral

Whenever the delivery of care to a patient requires diagnostic and therapeutic modalities that are beyond a dentist's scope of services, the dentist has the obligation to inform the patient of all available



treatment options and to refer the patient to a provider who is qualified to provide consultation or necessary care.

Some third party<sup>1</sup> payer contracts restrict a contracting dentist's scope of referral to specialists who have contractual arrangements with the payer. Some third party<sup>1</sup> payers also restrict the circumstances under which referrals may be made to contracting specialists. If a dentist believes a patient's condition requires services beyond a third party<sup>1</sup> payer's contracted services or providers, a dentist has the obligation to inform the patient of all available options in order that the patient may decide whether to seek services available within the contracted plan or to accept an outside referral at his or her own expense.

When a patient visits or is referred to a specialist or consulting dentist for consultation:

1. A dentist has the obligation to make a reasonable inquiry to determine whether a prospective patient is currently under the care of another dentist.
2. In the interest of preserving the continuity of care, a specialist or consulting dentist has the obligation to inform the patient of the need to continue care with the referring dentist, unless the patient expressly reveals a different preference.
3. When there is no referring dentist and upon completion of the treatment, a specialist or consulting dentist has the obligation to inform the patient when there is a need for further dental care.

## Section 10. Expert Testimony

A dentist may provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.

### 10A. Conflict of Interest

It is unethical for a dentist to engage in activities where personal or professional interests may conflict with the dentist's duties as an expert witness. It is unethical for a dentist to use information learned as expert witness for personal gain or advantage. If a dentist accepts a request from an attorney to provide an expert opinion about a person who is not a patient of the dentist, the dentist shall not accept that person as a patient into his or her practice until the litigation or other proceeding, if any, involving that person has concluded.

### 10B. Statements on Policies

A dentist has the right to speak out against any policies espoused by organized dentistry, provided the dentist does not misrepresent such policies. It is unethical, however, for a dentist to represent his or her views as those of the dental society or as those of the majority of the dentists of the community when, in fact, those views are opposed to those of the society or the majority of dentists in the community.

### 10C. Fair and Reasonable Comments

A dentist has the right to make fair comments with respect to dental health subjects, including dentists and the quality of dental care delivered and costs related thereto. However, it is unethical to publish, cause to be published or encourage the publication of comments on such subjects if the dentist does so without having sufficient information that would justify a reasonable dentist to believe the comments to be true. The burden shall be on the commenting dentist to produce the evidence upon which the comments were based and to establish therefrom that a reasonable dentist would be justified in believing the comments to be true. For the purposes of this section, the word "publication" means any form of communication, including, without limitation, the press, radio, television and lecture.

## Section 11. Rebates, Split Fees and Other Fee Arrangements

It is unethical for a dentist to accept or tender "rebates" or "split fees." Other fee arrangements between dentists or other persons or entities of the healing arts which are not disclosed to the patient are unethical.

Advisory Opinion:

11.A.1. Split Fees in Advertising and Marketing Services: The prohibition against a dentist's accepting or tendering rebates or split fees applies to business dealings between dentists and any third party, not just other dentists. Thus, a dentist who pays for advertising or marketing services by sharing a specified portion of the professional fees collected from prospective or actual patients with the vendor providing the advertising or marketing services is engaged in fee splitting. The prohibition against fee splitting is also applicable to the marketing of dental treatments or procedures via "social coupons" if the business arrangement between the dentist and the concern providing the marketing services for that treatment or those procedures allows the issuing company to collect the fee from the prospective patient, retain a defined percentage or portion of the revenue collected as payment for the coupon marketing service provided to the dentist and remit to the dentist the remainder of the amount collected. The prohibition against fee splitting is not applicable to marketing via group advertising or referral services that do not base their fees on the number of referrals or amount of professional fees paid by the patient to the dentist.

<sup>1</sup>A third party is any party to a dental prepayment contract that may collect premiums, assume financial risks, pay claims, and/or provide administrative services.

## Code Enforcement

The association's Code of Ethics, although presented in the form of general guidelines, clearly suggests the conduct that a dentist is



expected to follow in carrying out professional activities whether they are related to patients or to fellow practitioners.

Problems involving questions of ethics should be solved within the broad boundaries established in this Code of Ethics and within the meaning and interpretation of the Code of Ethics and Bylaws of the constituent and component societies. If a satisfactory decision cannot be reached, the question should be referred, on appeal, to the Council on Ethics, Bylaws and Judicial Affairs of the American Dental Association, as provided in Chapter XII of the Bylaws of the American Dental Association, and also in Chapter XI of the Bylaws of the California Dental Association.

### **Resources**

American Dental Association *Principles of Ethics and Code of Professional Conduct*

American Dental Association *Constitution and Bylaws*

State of California Department of Consumer Affairs *Dental Practice Act*

California Dental Association *Bylaws*

# **COLORADO DENTAL BOARD**

## **BOARD POLICIES**

(Updated February 2016)

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4. Intraoral tissues and structures should be examined and evaluated. When indicated, a timely referral to other dental specialists or health care providers should be made and documented.
5. The teeth and their replacements should be examined and evaluated. When indicated a timely referral to other dental specialist or health care provider should be made and documented.
6. Radiographs of diagnostic quality that are current, based on the diagnostic need of the patient are required. The dentist who prescribed the radiographs is responsible for their interpretation or obtaining an interpretation as they relate to all aspects of the teeth and surrounding structures. When indicated, a timely referral to other dental specialists or health care providers should be made and documented.
7. An evaluation of the periodontium is required. The Periodontal Screening and Recording Examination (PSR) or an equivalent examination can be utilized as a screening tool. When indicated, a more comprehensive charting record must be completed and/or an appropriate referral made. When indicated, a timely referral to other dental specialists or health care providers should be made and documented.
8. All relevant clinical findings should be documented in the patient's record.
9. Based on the results of the examination, a diagnosis and proposed treatment plan and options should be presented to the patient. Consequences of no treatment should be explained to the patient.

#### **4.E. INDEPENDENT MEDICAL EXAMINATIONS (IMEs) (Adopted 6/11/1997) (Amended 2/13/2002)**

For the purposes of this policy, the State Board defines an Independent Medical Examination, or IME, as an examination performed by a Colorado licensed practitioner at the request of a third party for the purposes of determining one or all of the following: insurance policy coverage, adequacy of care to date, reasonableness of fees, recommendation for further care and/or additional diagnostic work and needed referrals. This definition of IMEs does not include second opinions performed at the request of the patient or the treating doctor.

The Dental Practice Law of Colorado (December 30, 1996) §12-35-110 (1) (o) states that "a person is deemed to be practicing dentistry if, in the course of legitimate professional practice, such person gives or professes to give interpretations or reading of dental charts or records or gives treatment plans or interpretations of treatment plans derived from examinations, patient records, dental x-rays or roentgenograms;"

Relative to the definition of IME's and the Dental Law of Colorado, it is the position of the State Board of Dental Examiners that in the course of doing business a third party is entitled to seek an IME and that a third party is entitled to advise the subscriber of policy coverage. However, when a subscriber is provided with an interpretation of charts or radiographs, diagnosis, opinion on treatment or treatment plan, then the third party as well as the independent practitioner are deemed to be practicing dentistry. These interpretations can only be provided to the patient or guardian by a practitioner licensed to practice dentistry in the state of Colorado. Doing so without an appropriate license is a violation of the Dental Law of Colorado. Those licensees that provide such interpretations, diagnostic opinions, or treatment plans are held to the same standard as any Colorado licensed dentist as it relates to patient examination, diagnosis, and treatment planning.

#### **4.F. ON CALL COVERAGE (Adopted 8/14/2002)**

The Colorado Board of Dental Examiners determines on call coverage for a dentist or dental hygienist to be adequate when a mutually arranged covering dentist or dental hygienist is identified and the procedure to reach that professional is made readily available to patients of record.

#### **4.G. PATIENT ABANDONMENT (Adopted 8/14/2002)**

The Colorado Board of Dental Examiners defines patient abandonment as the unilateral termination of care of a patient of record on the part of the dentist or dental hygienist. As a patient and dentist or dental hygienist enter into a professional relationship, that dentist or dental hygienist has the responsibility for continuity or continuous care until either party chooses to discontinue the relationship. At the time at which the dentist or dental hygienist chooses to discontinue, he or she must notify the patient in writing noting with due diligence that the clinician will be available for emergency care and/ or appropriate referrals for 30 days from the date of the letter. The Colorado Board of Dental Examiners defines a patient of record as one who has been treated by that dentist or dental hygienist within the previous two years.

#### **4.H. PATIENT RECORDS: CHARGES FOR COPYING (Adopted 7/15/1998)**

The Board recognizes the regulations of the Colorado Department of Public Health and Environment on Patient Records in the Custody in Individual Health Care Providers.

5.3 Patient Records in custody of individual Health Care Providers (Outpatient Records). The law provides that upon receipt of a properly written authorization request:

5.3.3 The custodian of record shall make a copy of the record available or make the record available for inspection within a reasonable time from the date of the signed request, normally not to exceed five days, excluding weekends and holidays.

5.3.5 The discharged patient or representative shall pay for the reasonable cost to obtain a copy of his/her patient record, not to exceed \$12 for the first ten or fewer pages and \$.25 per page for every additional page. Actual postage costs may also be charged. For one or more specific classes of records (such as x-rays or radiographs) or services, facilities may charge additional sums upon presenting a justification therefore acceptable to the Department.

#### **4.I. PATIENT RECORDS: REFUSAL TO RELEASE (Adopted 11/20/1991)**

1. When a complaint is received that the patient has provided written request to the dentist for his/her records and the dentist has not complied, the complaint is to be reviewed by the Board.
2. When neither the patient nor the dentist have complied with the statute requirements, the Board staff will send a letter to both parties explaining the provisions and responsibilities under the statute.
3. When both the dentist and the patient have been notified of the provisions of the statute, the patient provided written request to the dentist, and the dentist does not comply, the complaint is to be reviewed by the Board.

#### **4.J. MEDICAL IMMOBILIZATION / PROTECTIVE STABILIZATION / RESTRAINTS (Adopted 8/11/2004)**

- A. Within this policy, the terms medical immobilization, protective stabilization, and restraint are used interchangeably.
- B. The purpose of this policy is to recognize the fact that pediatric and special needs patients may need to be medically immobilized or restrained in order to prevent injury and to protect the health and safety of the patients, the dentist, and the dental staff. To achieve this, it is important to build a trusting relationship between the dentist, the dental staff, the patient, and the parent or guardian. This necessitates that the dentist establishes communication with them and promotes a positive attitude towards oral and dental health in order to alleviate fear and anxiety and to deliver quality dental care.
- C. Training requirement. Prior to utilizing medical immobilization, the dentist shall have received training beyond basic dental education through a residency program, graduate program, or an extensive continuing education course that involves both didactic and experiential mentored training.

**TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING**  
**CHAPTER 5 DENTISTRY (DENTISTS, DENTAL HYGIENISTS, ETC.)**  
**PART 16 DENTISTS, DISCIPLINARY PROCEEDINGS, LICENSE REVOCATION OR**  
**SUSPENSION FOR DISCIPLINARY ACTIONS**

**16.5.16.1 ISSUING AGENCY:** New Mexico Board of Dental Health Care.  
[9-30-96; 16.5.16.1 NMAC - Rn & A, 16 NMAC 5.16.1, 12-14-00]

**16.5.16.2 SCOPE:** The provisions of 16.5.16 NMAC apply to all active license holders and applicants for licensure. These provisions may also be of interest to anyone who may wish to file a complaint against a dentist licensed by the board.  
[9-30-96; 16.5.16.2 NMAC - Rn, 16 NMAC 5.16.2, 12-14-00]

**16.5.16.3 STATUTORY AUTHORITY:** 16.5.16 NMAC is promulgated pursuant to the Dental Health Care Act, NMSA 1978, Section 61-5A-21 (1996 Repl. Pamp.).  
[9-30-96; 16.5.16.3 NMAC - Rn, 16 NMAC 5.16.3, 12-14-00]

**16.5.16.4 DURATION:** Permanent.  
[9-30-96; 16.5.16.4 NMAC - Rn, 16 NMAC 5.16.4, 12-14-00]

**16.5.16.5 EFFECTIVE DATE:** September 30, 1996, unless a later date is cited at the end of a section.  
[9-30-96; 16.5.16.5 NMAC - Rn, 16 NMAC 5.16.5, 12-14-00; A, 07-19-10]

**16.5.16.6 OBJECTIVE:** To establish the procedures for filing complaints against licensees, the disciplinary actions available to the board, the authority to issue investigative subpoenas and to further define actions by a licensee which are considered incompetent or unprofessional practice.  
[9-30-96; 16.5.16.6 NMAC - Rn, 16 NMAC 5.16.6, 12-14-00]

**16.5.16.7 DEFINITIONS:**

A. "Addiction" means a neurobehavioral syndrome with genetic and environmental influences that result in psychological dependence on the use of substances for their psychic effects. It is characterized by behaviors that include one or more of the following: impaired control over drug use; compulsive use; continued use despite harm; and craving.

B. "Chronic pain" means a pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated.

C. "Direct reference" means a phone number or website where names and contact information of the dentist(s) can be referenced.

D. "Drug abuser" means a person who takes a drug or drugs for other than legitimate medical purposes.

E. "Pain" means an unpleasant sensory and emotional experience associated with inflammation or with actual or potential tissue damage, or described in terms of such inflammation or damage.

F. "Patient abandonment" means withdrawing a patient from treatment without giving reasonable notice or providing a competent replacement provider.

G. "Physical dependence" means a state of adaptation that is manifested by a drug-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, administration of an antagonist, or a combination of these.

H. "Tolerance" means a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.

[9-30-96; 16.5.16.7 NMAC - Rn, 16 NMAC 5.16.7, 12-14-00; A, 01-09-12; A, 07-17-13]

**16.5.16.8 COMPLAINTS:** Disciplinary proceedings may be instituted by sworn complaint of any person, including members of the board and committee. Any hearing held pursuant to the complaint shall conform with the provisions of the Uniform Licensing Act, the Dental Health Care Act or the Impaired Dentists and Dental Hygienists Act.

[9-13-69...5-31-95; 16.5.16.8 NMAC - Rn, 16 NMAC 5.16.8, 12-14-00; A, 06-14-12]

**16.5.16.9 ACTIONS:**

A. The board may fine, deny, revoke, suspend, stipulate, or otherwise limit a license if the board determines the licensee is guilty of violating any of the provisions of the Act, the Uniform Licensing Act, the Impaired Dentists and Hygienists Act, or these Rules.

B. The board may reprimand, censure, or require licensees to fulfill additional continuing education hours within limited time constraints for violations of the Act or Rules.

[9-13-69, 4-29-82, 5-31-95; 16.5.16.9 NMAC - Rn, 16 NMAC 5.16.9, 12-14-00]

**16.5.16.10 GUIDELINES:** The board shall use the following as guidelines for disciplinary action.

A. "Gross incompetence" or "gross negligence" means, but shall not be limited to, a significant departure from the prevailing standard of care in treating patients.

B. "Unprofessional conduct" means, but is not limited to because of enumeration:

- (1) performing, or holding oneself out as able to perform, professional services beyond the scope of one's license and field or fields of competence as established by education, experience, training, or any combination thereof; this includes, but is not limited to, the use of any instrument or device in a manner that is not in accordance with the customary standards and practices of the dental profession;
- (2) failure to refer a patient, after emergency treatment, to his/her regular dentist and inform the latter of the conditions found and treated;
- (3) failure to release to a patient copy of that patient's records and x-rays within 15 business days regardless whether patient has an outstanding balance;
- (4) failure to seek consultation whenever the welfare of the patient would be safeguarded or advanced by referral to individuals with special skills, knowledge, and experience;
- (5) failure to advise the patient in simple understandable terms of the proposed treatment, the anticipated fee, the expectations of success, and any reasonable alternatives;
- (6) failure of a dentist to comply with the following advertising guidelines, no person shall:
  - (a) practice dentistry under the name of a corporation, company, association, limited liability company, or trade name without full and outward disclosure of his/her full name, which shall be the name used in his/her license or renewal certificate as issued by the board, or his/her commonly used name;
  - (b) practice dentistry without displaying his/her full name as it appears on the license issued by the board on the entrance of each dental office;
  - (c) fail to include in all advertising media for the practice (excluding building signage and promotional items), in a reasonably visible and legible manner, the dentist's names(s), address and telephone number or direct reference where the name of the dentist(s) can be found as defined in 16.5.16.7 NMAC;
  - (d) advertise a practice in a false, fraudulent or misleading manner; if the name of the practice or office contains one of the American dental association recognized specialties and only a general dentist performs that service, the advertisement, signage, or broadcast media must say "services provided by a general dentist", so as not to imply that a specialist is performing such procedures; and
  - (e) advertise as a specialist unless the dentist is licensed by the board to practice the specialty or unless the dentist has earned a post-graduate degree or certificate from an accredited dental college, school of dentistry of a university or other residency program that is accredited by commission on dental accreditation (CODA) in one of the specialty areas of dentistry recognized by the American dental association;
- (7) failure to use appropriate infection control techniques and sterilization procedures;
- (8) deliberate and willful failure to reveal, at the request of the board, the incompetent, dishonest, or corrupt practices of another dentist licensed or applying for licensure by the board;
- (9) accept rebates, or split fees or commissions from any source associated with the service rendered to a patient; provided, however, the sharing of profits in a dental partnership, association, HMO or DMO, or similar association shall not be construed as fee-splitting, nor shall compensating dental hygienists or dental assistants on a basis of percentage of the fee received for the overall service rendered be deemed accepting a commission;
- (10) prescribe, dispense or administer drugs outside the scope of dental practice;
- (11) charge a patient a fee which is not commensurate with the skill and nature of services rendered, such as to be unconscionable;
- (12) sexual misconduct;
- (13) breach of ethical standards, an inquiry into which the board will begin by reference to the code of ethics of the American dental association;
- (14) the use of a false, fraudulent or deceptive statement in any document connected with the practice of dentistry;
- (15) employing abusive billing practices;
- (16) fraud, deceit or misrepresentation in any application;

- (17) violation of any order of the board, including any probation order;
  - (18) injudicious prescribing, administration, or dispensing of any drug or medicine;
  - (19) failure to report to the board any adverse action taken by any licensing board, peer review body, malpractice insurance carrier or any other entity as defined by the board or committee; the surrender of a license to practice in another state, surrender of membership on any medical staff or in any dental or professional association or society, in lieu of, and while under disciplinary investigation by any authority;
  - (20) negligent supervision of a dental hygienist or dental assistant;
  - (21) cheating on an examination for licensure; or
  - (22) failure to comply with the terms of a signed collaborative practice agreement;
  - (23) failure of a dentist of record, or consulting dentist, to communicate with a collaborative practice dental hygienist in an effective professional manner in regard to a shared patient's care under part 17 of these rules;
  - (24) assisting a health professional, or being assisted by a health professional that is not licensed to practice by a New Mexico board, agency or commission;
  - (25) failure to make available to current patients of record a reasonable method of contacting the treating dentist or on-call service for dental emergencies; dental practices may refer patients to an alternate urgent care or emergency facility if no other option is available at the time, or if the contacted dentist deems it necessary for the patient's well-being;
  - (26) conviction of either a misdemeanor or a felony punishable by incarceration;
  - (27) aiding and abetting a dental assistant, expanded function dental auxiliary or community dental health coordinator who is not properly certified;
  - (28) patient abandonment;
  - (29) habitually addicted as defined in NMSA 1978, Sections 61.5A-21 4 & 6 or 61.5B-3 (C) and (D) habitual or excessive use or abuse of drugs, as defined in the Controlled Substances Act [30-31-1 NMSA 1978] or habitual or excessive use or abuse of alcohol;
  - (30) failure of the licensee to furnish the board within 10 business days of request, its investigators or representatives with information requested by the board;
  - (31) failure to appear before the board when requested by the board in any disciplinary proceeding;
  - (32) failure to be in compliance with the Parental Responsibility Act NMSA1978, Section 40-5A-3 seq.;
  - (33) fraudulent record keeping;
  - (34) failure to properly install amalgam separator as defined in 16.5.58 NMAC;
  - (35) failure to properly operate and maintain amalgam separator as defined in 16.5.58 NMAC;
- and
- (36) failure to properly dispose of amalgam waste as defined in 16.5.58 NMAC.
- [9-13-69, 10-21-70, 4-11-81, 3-9-89, 3-11-89, 10-16-92, 5-31-95, 6-4-96, 2-14-00; 16.5.16.10 NMAC - Rn & A, 16 NMAC 5.16.10, 12-14-00; A, 07-16-07; A, 07-19-10; A, 01-09-12; A, 06-14-12; A, 07-17-13; A, 01-04-14; A, 01-15-15]

**16.5.16.11 INVESTIGATIVE SUBPOENAS:** The complaint committee of the board is authorized to issue investigative subpoenas and to employ experts with regard to pending investigations.  
[5-31-95; 16.5.16.11 NMAC - Rn, 16 NMAC 5.16.11, 12-14-00; A, 07-16-07; A, 07-17-08]

**16.5.16.12 REVOCATION OF LICENSE FOR DISCIPLINARY ACTIONS:** A licensee whose license is revoked for disciplinary actions shall:

- A. provide proof of written notification of practice closure to all patients currently under active treatment;
- B. notification to patients should include where and how dental treatment records may be obtained and contact information for dentists available; and
- C. provide to the board the location where all active dental treatment records will be maintained for a minimum of six years; active treatment records are records of patients treated in the two years previous to the date of closure; the notification to the board shall include the name, address, and telephone number of the person who is serving as the custodian of the records.

[16.5.16.12 NMAC - N, 01-09-12]

**16.5.16.13 REINSTATEMENT OF REVOKED LICENSE FOR DISCIPLINARY ACTIONS:** A licensee whose license has been revoked for disciplinary actions may request reinstatement of the license after the

**61-5A-21. Disciplinary proceedings; application of Uniform Licensing Act. (Repealed effective July 1, 2024.)**

A. In accordance with the Uniform Licensing Act [[61-1-1](#) through [61-1-31](#) NMSA 1978] and rules of the board, the board and committee may fine and may deny, revoke, suspend, stipulate or otherwise limit any license or certificate, including those of licensed non-dentist owners, held or applied for under the Dental Health Care Act, upon findings by the board or the committee that the licensee, certificate holder or applicant:

- (1) is guilty of fraud or deceit in procuring or attempting to procure a license or certificate;
- (2) has been convicted of a crime punishable by incarceration in a federal prison or state penitentiary; provided a copy of the record of conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence of such conviction;
- (3) is guilty of gross incompetence or gross negligence, as defined by rules of the board, in the practice of dentistry, dental hygiene or dental assisting;
- (4) is habitually intemperate or is addicted to the use of habit-forming drugs or is addicted to any vice to such degree as to render the licensee unfit to practice;
- (5) is guilty of unprofessional conduct as defined by rule;
- (6) is guilty of any violation of the Controlled Substances Act [[Chapter 30, Article 31](#) NMSA 1978];
- (7) has violated any provisions of the Dental Health Care Act or rule or regulation of the board or the committee;
- (8) is guilty of willfully or negligently practicing beyond the scope of licensure;
- (9) is guilty of practicing dentistry or dental hygiene without a license or aiding or abetting the practice of dentistry or dental hygiene by a person not licensed under the Dental Health Care Act;
- (10) is guilty of obtaining or attempting to obtain any fee by fraud or misrepresentation or has otherwise acted in a manner or by conduct likely to deceive, defraud or harm the public;
- (11) is guilty of **patient abandonment** ;
- (12) is guilty of failing to report to the board any adverse action taken against the licensee by a licensing authority, peer review body, malpractice insurance carrier or other entity as defined in rules of the board and the committee;
- (13) has had a license, certificate or registration to practice as a dentist or dental hygienist revoked, suspended, denied, stipulated or otherwise limited in any jurisdiction, territory or possession of the United States or another country for actions of the licensee similar to acts described in this subsection. A certified copy of the decision of the jurisdiction taking such disciplinary action will be conclusive evidence; or
- (14) has failed to furnish the board, its investigators or its representatives with information requested by the board or the committee in the course of an official investigation.

B. Disciplinary proceedings may be instituted by sworn complaint by any person, including a board or committee member, and shall conform with the provisions of the Uniform Licensing Act.

C. Licensees and certificate holders shall bear the costs of disciplinary proceedings unless exonerated.

D. Any person filing a sworn complaint shall be immune from liability arising out of civil action if the complaint is filed in good faith and without actual malice.

E. Licensees whose licenses are in a probationary status shall pay reasonable expenses for maintaining probationary status, including but not limited to laboratory costs when laboratory testing of biological fluids or accounting costs when audits are included as a condition of probation.

**History:** Laws 1994, ch. 55, § 21; 2003, ch. 409, § 17.

## Office of the Professions

# Rules of the Board of Regents

## Part 29, Unprofessional Conduct

Effective October 5, 2011

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[§ 29.1 - General provisions.](#) | [§ 29.2 - General provisions for health professions.](#) | [§ 29.3 - General provisions for design professions.](#) | [§ 29.4 - Special provisions for the profession of medicine.](#) | [§ 29.5 - Special provisions for the professions of dentistry and dental hygiene.](#) | [§ 29.6 - Special provisions for the profession of veterinary medicine.](#) | [§ 29.7 - Special provisions for the profession of pharmacy.](#) | [§ 29.8 - Special provisions for the profession of optometry.](#) | [§ 29.9 - Special provisions for the profession of ophthalmic dispensing.](#) | [§ 29.10 - Special provisions for the profession of public accountancy.](#) | [§ 29.11 - Special provisions for the profession of certified shorthand reporting.](#) | [§ 29.12 - Special provisions for the profession of psychology.](#) | [§ 29.13 - Special provisions for the profession of massage therapy.](#) | [§ 29.14 - Special provisions for the profession of nursing.](#) | [§ 29.15 - Special provisions for the professions of creative arts therapy, marriage and family therapy, mental health counseling, and psychoanalysis.](#) | [§ 29.16 - Special provisions for the social work professions.](#) | [§ 29.17. Special provisions for the profession of physical therapy.](#) | [§ 29.18. Unprofessional conduct in waived entities.](#) | [§ 29.19. Special provisions for the profession of midwifery.](#)

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### § 29.1 General provisions.

- a. Unprofessional conduct shall be the conduct prohibited by this section. The provisions of these rules applicable to a particular profession may define additional acts or omissions as unprofessional conduct and may establish exceptions to these general prohibitions.
- b. Unprofessional conduct in the practice of any profession licensed, certified or registered pursuant to title VIII of the Education Law, except for cases involving those professions licensed, certified or registered pursuant to the provisions of Article 131 or 131-B of such law in which a statement of charges of professional misconduct was not served on or before July 26, 1991, the effective date of Chapter 606 of the Laws of 1991, shall include:
  1. willful or grossly negligent failure to comply with substantial provisions of Federal, State or local laws, rules or regulations governing the practice of the profession;
  2. exercising undue influence on the patient or client, including the promotion of the sale of services, goods, appliances or drugs in such manner as to exploit the patient or client for the financial gain of the practitioner or of a third party;
  3. directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services;
  4. permitting any person to share in the fees for professional services, other than: a partner, employee, associate in a professional firm or corporation, professional subcontractor or consultant authorized to practice the same profession, or a legally authorized trainee practicing under the supervision of a licensed practitioner. This prohibition shall include any arrangement or agreement whereby the amount received in payment for furnishing space, facilities, equipment or personnel services used by a professional licensee constitutes a percentage of, or is otherwise dependent upon, the income or receipts of the licensee from such practice, except as otherwise provided by law with respect to a facility licensed pursuant to Article 28 of the Public Health Law or Article 13 of the Mental Hygiene Law;
  5. conduct in the practice of a profession which evidences moral unfitness to practice the profession;
  6. willfully making or filing a false report, or failing to file a report required by law or by the Education Department, or willfully impeding or obstructing such filing, or inducing another person to do so;
  7. failing to make available to a patient or client, upon request, copies of documents in the

possession or under the control of the licensee which have been prepared for and paid for by the patient or client;

8. revealing of personally identifiable facts, data or information obtained in a professional capacity without the prior consent of the patient or client, except as authorized or required by law;
9. practicing or offering to practice beyond the scope permitted by law, or accepting and performing professional responsibilities which the licensee knows or has reason to know that he or she is not competent to perform, or performing without adequate supervision professional services which the licensee is authorized to perform only under the supervision of a licensed professional, except in an emergency situation where a person's life or health is in danger;
10. delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience or by licensure, to perform them;
11. performing professional services which have not been duly authorized by the patient or client or his or her legal representative;
12. advertising or soliciting for patronage that is not in the public interest:
  - i. Advertising or soliciting not in the public interest shall include, but not be limited to, advertising or soliciting that:
    - a. is false, fraudulent, deceptive or misleading;
    - b. guarantees any service;
    - c. makes any claim relating to professional services or products or the cost or price therefore which cannot be substantiated by the licensee, who shall have the burden of proof;
    - d. makes claims of professional superiority which cannot be substantiated by the licensee, who shall have the burden of proof; or
    - e. offers bonuses or inducements in any form other than a discount or reduction in an established fee or price for a professional service or product.
  - ii. The following shall be deemed appropriate means of informing the public of the availability of professional services:
    - a. informational advertising not contrary to the foregoing prohibitions; and
    - b. the advertising in a newspaper, periodical or professional directory or on radio or television of fixed prices, or a stated range of prices, for specified routine professional services, provided that if there is an additional charge for related services which are an integral part of the overall service being provided by the licensee, the advertisement shall so state, and provided further that the advertisement indicates the period of time for which the advertised prices shall be in effect.
  - iii.
    - a. all licensees placing advertisements shall maintain, or cause to be maintained, an exact copy of each advertisement, transcript, tape or videotape thereof as appropriate for the medium used, for a period of one year after its last appearance. This copy shall be made available for inspection upon demand of the Education Department;
    - b. a licensee shall not compensate or give anything of value to representatives of the press, radio, television or other communications media in anticipation of or in return for professional publicity in a news item;
  - iv. Testimonials, demonstrations, dramatizations, or other portrayals of professional practice are permissible provided that they otherwise comply with the rules of professional conduct and further provided that the following conditions are satisfied:
    - a. the patient or client expressly authorizes the portrayal in writing;
    - b. appropriate disclosure is included to prevent any misleading information or imagery as to the identity of the patient or client;
    - c. reasonable disclaimers are included as to any statements made or results achieved in a particular matter;
    - d. the use of fictional situations or characters may be used if no testimonials are

included; and  
e. fictional client testimonials are not permitted;

13. failing to respond within 30 days to written communications from the Education Department or the Department of Health and to make available any relevant records with respect to an inquiry or complaint about the licensee's unprofessional conduct. The period of 30 days shall commence on the date when such communication was delivered personally to the licensee. If the communication is sent from either department by registered or certified mail, with return receipt requested, to the address appearing in the last registration, the period of 30 days shall commence on the date of delivery to the licensee, as indicated by the return receipt;

14. violating any term of probation or condition or limitation imposed on the licensee by the Board of Regents pursuant to Education Law, Section 6511.

## § 29.2 General provisions for health professions.

a. Unprofessional conduct shall also include, in the professions of: acupuncture, athletic training, audiology, certified behavior analyst assistant, certified dental assisting, chiropractic, creative arts therapy, dental hygiene, dentistry, dietetics/nutrition, licensed behavior analyst, licensed practical nursing, marriage and family therapy, massage therapy, medicine, mental health counseling, midwifery, occupational therapy, occupational therapy assistant, ophthalmic dispensing, optometry, pharmacy, physical therapist assistant, physical therapy, physician assistant, podiatry, psychoanalysis, psychology, registered professional nursing, respiratory therapy, respiratory therapy technician, social work, specialist assistant, speech-language pathology (except for cases involving those professions licensed, certified or registered pursuant to the provisions of article 131 or 131-B of the Education Law in which a statement of charges of professional misconduct was not served on or before July 26, 1991, the effective date of chapter 606 of the Laws of 1991):

1. abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, or abandoning a professional employment by a group practice, hospital, clinic or other health care facility, without reasonable notice and under circumstances which seriously impair the delivery of professional care to patients or clients;
2. willfully harassing, abusing or intimidating a patient either physically or verbally;
3. failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Unless otherwise provided by law, all patient records must be retained for at least six years. Obstetrical records and records of minor patients must be retained for at least six years, and until one year after the minor patient reaches the age of 21 years;
4. using the word "Doctor" in offering to perform professional services without also indicating the profession in which the licensee holds a doctorate;
5. failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensed professional;
6. guaranteeing that satisfaction or a cure will result from the performance of professional services;
7. ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient;
8. claiming or using any secret or special method of treatment which the licensee refuses to divulge to the State Board for the profession;
9. failing to wear an identifying badge, which shall be conspicuously displayed and legible, indicating the practitioner's name and professional title authorized pursuant to the Education Law, while practicing as an employee or operator of a hospital, clinic, group practice or multiprofessional facility, registered pharmacy, or at a commercial establishment offering health services to the public;
10. entering into an arrangement or agreement with a pharmacy for the compounding and/or dispensing of coded or specially marked prescriptions;
11. with respect to all professional practices conducted under an assumed name, other than facilities

## POLICY REGARDING TERMINATION OF THE DENTIST-PATIENT RELATIONSHIP

Preamble: The purpose of this policy is to clarify the Board's position regarding what should be considered when terminating the dentist-patient relationship.

It is the position of the Ohio State Dental Board that the following elements should be satisfied prior to terminating the dentist-patient relationship:

1. All efforts should be made to give the patient sufficient notice of termination of dental services.
2. All efforts should be made to stabilize the patient's dental condition and not place the patient's dental health in immediate jeopardy.
3. Upon written request, a copy of all records should be made available to the patient or the subsequent treating practitioner.

The Board traditionally has held that if a dentist has abandoned the patient, he or she potentially has violated the standard of care for the profession which may be grounds for discipline pursuant to Ohio Revised Code 4715.30 (A)(7). Dentists following these minimum guidelines will likely be considered to be following appropriate termination procedures and thus giving an indication that the patient has not been abandoned.

Approved October 23, 2013

## PATIENT RECORD POLICY

Preamble: The purpose of this policy is to clarify the Board's position regarding what should be considered as an accurate and up to date patient record which would conform to the accepted standards for the profession.

It is the position of the Ohio State Dental Board that all patients should have accurate and current dental records to document clinical findings and procedures.

The purpose of this policy is to clarify the Board's position regarding the ownership and release of patient records.

### Patient Record Defined:

Ohio Revised Code section 3701.74 defines a medical record as:

Data in any form that pertains to a patient's medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient's health care treatment." This would include:

- medical/dental history
- written progress notes
- radiographs
- models, and other treatment information.

### Ownership:

Patient records belong to the treating dentist, or the dentist owner of the dental practice if so provided for under contract. Regardless of a dentist's employment or practice situation, it is important that the dentist account for the ownership and responsibility for the safeguarding of patient records to ensure a continuity of care and avoid patient abandonment. Despite owning the patient record, dentists have a legal obligation to provide a copy or allow for examination of that record upon the receipt of a written request from the patient, the patient's parent or legal guardian, or another properly authorized person.

### Transfer of Ownership:

Patient records may be transferred to another licensed dentist in the event of the sale of a dental practice, a change in employment by the treating dentist, or other circumstance in order to ensure a continuity of care.

The Health Insurance Portability and Accountability Act (HIPAA) allows for the transfer of patients' protected health information to complete treatment, payment and health care operations. Ideally, dentists involved with the transfer of a patient's record in one of these circumstances should attempt to notify the patient of the transfer and how to obtain a copy of their record should they choose.

In the event of the death of the owner of a dental practice, the records can be held by the estate while arrangements are made for the eventual sale of the dental practice to another licensed dentist. Ohio Revised Code section 4715.01 states that only a licensed dentist can be an owner, operator, or manager of a place for performing dental operations. During the transition period following the death of a dentist, dental care, including supervision of the dental hygienist(s) and auxiliary dental staff, can continue for a period of 90 days by an interim dentist(s) at which time the Board will inquire as to the permanent arrangement.

### Costs:

Dentists may charge a reasonable fee for the copying of a patient's record in accordance with the limitations set forth in Ohio Revised Code section 3701.741. However, a patient's right to obtain a copy of that record is absolute and the dentist's obligation to provide a copy of the record exists regardless of a patient's account balance.

### Termination:

In the case of termination of the patient relationship, upon written request, the records should be available to the patient or subsequent treating practitioner.

Approved October 23, 2013

## **4731-27-03 Notice of termination of physician employment or physician leaving a practice, selling a practice, or retiring from the practice of medicine.**

(A) When pursuant to section [4731.228](#) of the Revised Code a health care entity provides to patients a notice of the termination of a physician's employment, the notice shall be provided in one of the following ways:

- (1) A letter sent via regular mail to the last address for the patient on record, with the date of mailing of the letter documented;
- (2) An electronic message sent via a HIPAA compliant electronic medical record system or HIPAA compliant electronic health record system that provides a means of electronic communication between the health care entity and the patient and is capable of sending the patient a notification that a message has been received and is in the patient's portal.

(B) When pursuant to section [4731.228](#) of the Revised Code a health care entity provides the physician whose employment has been terminated for any reason with a list of patients treated and the patient contact information, the physician shall provide the notice required by section [4731.228](#) of the Revised Code by one of the ways authorized by paragraph (A)(1) or (A)(2) of this rule. In addition, the physician may, but is not required to, publish a notice in a newspaper of greatest circulation in the county in which the physician has practiced and in a local newspaper that serves the immediate practice area.

(C) Except as provided in paragraph (D) of this rule, a physician who is an independent contractor or who has an ownership interest in a health care entity shall provide notice in compliance with the following requirements when leaving, selling, or retiring from the health care entity where the physician has provided physician services:

(1) The notice shall be sent to all patients who received physician services from the physician within the two-years immediately preceding the physician's last date for seeing patients;

(2) The notice shall be provided as authorized in paragraph (A)(1) or (A)(2) of this rule.

(a) The notice shall be sent no later than thirty days prior to the last date the physician will see patients or upon actual knowledge that the physician will be leaving, selling, or retiring from the health care entity, whichever is earlier.

(b) A physician shall make a good faith effort to comply with paragraph (C)(2)(a) of this rule. However, a physician who because of acute illness or unforeseen emergency is unable to provide the notice thirty days prior to the last date of seeing patients shall provide the notice required by paragraph (C) of this rule no later than thirty days after it is determined that the physician will not be returning to the health care entity.

(3) The notice shall include all of the following:

(a) A statement that the physician will no longer be practicing medicine at the health care entity;

(b) The date on which the physician ceased or will cease to provide medicine services at the health care entity;

(c) If the physician will be practicing medicine in another location, contact information for the physician subsequent to leaving the health care entity;

(d) Contact information for an alternative physician or physicians employed by the health care entity or

contact information for a group practice that can provide care for the patient;

(e) Contact information that enables the patient to obtain information on the patient's medical records.

(D) The requirements of paragraphs (A), (B) and (C) of this rule do not apply to the following:

(1) A physician who rendered medical service to a person on an episodic basis or in an emergency department or urgent care center, when it should not be reasonably expected that related medical service will be rendered by the physician to the patient in the future;

(2) A medical director or other physician providing services in a similar capacity to a medical director to patients through a hospice care program licensed pursuant to section [3712.04](#) of the Revised Code;

(3) Medical residents, interns, and fellows who work in hospitals, health systems, federally qualified health centers, and federally qualified health center look-alikes as part of their medical education and training;

(4) A physician providing services to a patient through a community mental health agency certified by the director of mental health under section [5119.611](#) of the Revised Code or an alcohol and drug addiction program certified by the department of alcohol and drug addiction services under section [3793.06](#) of the Revised Code;

(5) A physician providing services to a patient through a federally qualified health center or a federally qualified health center look-alike.

(E) A physician's failure to provide notice in accordance with the provisions of paragraph (B) or (C) of this rule, as determined by the state medical board of Ohio, shall constitute "a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section [4731.22](#) of the Revised Code.

(F) Nothing in this rule shall limit the board's authority to investigate and take action under section [4731.22](#) of the Revised Code.

Replaces: part of 4731-27-01

Effective: 12/31/2013

R.C. [119.032](#) review dates: 12/31/2018

Promulgated Under: [119.03](#)

Statutory Authority: [4731.05](#), [4731.228](#)

Rule Amplifies: [4731.22](#), [4731.228](#)

Prior Effective Dates: 9/30/06

## Nonmaleficence

### SECTION 2 — Principle: Nonmaleficence ("do no harm").

The dentist has a duty to refrain from harming the patient.

*This principle expresses the concept that professionals have a duty to protect the patient from harm. Under this principle, the dentist's primary obligations include keeping knowledge and skills current, knowing one's own limitations and when to refer to a specialist or other professional, and knowing when and under what circumstances delegation of patient care to auxiliaries is appropriate.*

### Code of Professional Conduct

**2.A. Education.** The privilege of dentists to be accorded professional status rests primarily in the knowledge, skill and experience with which they serve their patients and society. All dentists, therefore, have the obligation of keeping their knowledge and skill current.

**2.B. Consultation And Referral.** Dentists shall be obliged to seek consultation, if possible, whenever the welfare of patients will be safeguarded or advanced by utilizing those who have special skills, knowledge, and experience. When patients visit or are referred to specialists or consulting dentists for consultation:

1. The specialists or consulting dentists upon completion of their care shall return the patient, unless the patient expressly reveals a different preference, to the referring dentist, or, if none, to the dentist of record for future care.
2. The specialists shall be obliged when there is no referring dentist and upon a completion of their treatment to inform patients when there is a need for further dental care.

### Advisory Opinion

**2.B.1. Second Opinions.** A dentist who has a patient referred by a third party<sup>1</sup> for a "second opinion" regarding a diagnosis or treatment plan recommended by the patient's treating dentist should render the requested second opinion in accordance with this Code of Ethics. In the interest of the patient being afforded quality care, the dentist rendering the second opinion should not have a vested interest in the ensuing recommendation.

**2.C. Use of Auxiliary Personnel.** Dentists shall be obliged to protect the health of their patients by only assigning to qualified auxiliaries those duties which can be legally delegated. Dentists shall be further obliged to prescribe and supervise the patient care provided by all auxiliary personnel working under their direction.

**2.D. Personal Impairment.** It is unethical for a dentist to practice while abusing controlled substances, alcohol or other chemical agents which impair the ability to practice. All dentists have an ethical obligation to urge chemically impaired colleagues to seek treatment. Dentists with first-hand knowledge that a colleague is practicing dentistry when so impaired have an ethical responsibility to report such evidence to the professional assistance committee of a dental society.

## **Advisory Opinion**

**2.D.1. Ability To Practice.** A dentist who contracts any disease or becomes impaired in any way that might endanger patients or dental staff shall, with consultation and advice from a qualified physician or other authority, limit the activities of practice to those areas that do not endanger patients or dental staff. A dentist who has been advised to limit the activities of his or her practice should monitor the aforementioned disease or impairment and make additional limitations to the activities of the dentist's practice, as indicated.

**2.E. Postexposure, Bloodborne Pathogens.** All dentists, regardless of their bloodborne pathogen status, have an ethical obligation to immediately inform any patient who may have been exposed to blood or other potentially infectious material in the dental office of the need for post exposure evaluation and follow-up and to immediately refer the patient to a qualified health care practitioner who can provide postexposure services. The dentist's ethical obligation in the event of an exposure incident extends to providing information concerning the dentist's own bloodborne pathogen status to the evaluating health care practitioner, if the dentist is the source individual, and to submitting to testing that will assist in the evaluation of the patient. If a staff member or other third person is the source individual, the dentist should encourage that person to cooperate as needed for the patient's evaluation.

**2.F. Patient Abandonment.** Once a dentist has undertaken a course of treatment, the dentist should not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist. Care should be taken that the patient's oral health is not jeopardized in the process.

**2.G. Personal Relationships with Patients.** Dentists should avoid interpersonal relationships that could impair their professional judgment or risk the possibility of exploiting the confidence placed in them by a patient.

### **Note:**

1. A third party is any party to a dental prepayment contract that may collect premiums, assume financial risks, pay claims, and/or provide administrative services.

# Guide to Closing a Dental Practice



Contains sample letters and tips to close a dental practice at retirement or in the event of a dentist's long-term illness or death

**ADA** American  
Dental  
Association®

America's leading  
advocate for oral health

## **The Mission Statement of the Council on Dental Practice:**

*The mission of the Council on Dental Practice is to recommend policies and provide resources to empower our members to continue development of the dental practice, and to enhance their personal and professional lives for the betterment of the dental team and the patients they serve.*

### **Disclaimer**

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## Introduction

The ADA membership figures indicate that in 2007 1,168 dentists retired. ***A Guide to Closing a Dental Practice*** contains useful information to help a dentist with the many details involved in ending a practice. Some dentists may close their practices due to retirement; others may face other financial challenges. A surviving spouse who is suddenly left with the daunting task of selling or closing a practice will also find this guide useful.

This publication contains information about informing patients and authorities of the closing of the practice; steps to dismissing the staff; disposing of dental equipment, supplies and instruments and about how to deal with patient records. Some states have specific record retention and patient & employee notification requirements that apply whenever a dentist decides to retire or close a practice (i.e. Florida's Administrative Rule 59Q-17.001 *Required Availability of Dental Records upon Relocation or Termination of Practice, or Death of Practitioner*). Check with your state or local dental society for specific information or with an attorney who knows about the requirements in your state (see Appendix D for contact information).

## Seek Competent Professional Advice

Prior to closing a practice, a dentist or surviving spouse should decide if the practice can be sold. The proceeds from a practice's sale can sometimes be an important asset for a dentist's estate or for funding his/her retirement years. Dentists and others considering closing a practice should always seek professional advice. Advisors could include an attorney, accountant or dental practice valuator. (For information that might help you better select advisors, see Appendix B). It is always a good idea for a dentist to make plans in advance for the sale or closing of the dental practice due to their disability or death. For the benefit of the surviving spouse, keep important papers in a single location; or at least, identify where essential documents can be found. Designate a "transition team" (accountant, lawyer & practice broker with dental client experience) and instruct them on how to proceed to a closing or sale depending on the circumstances.

## Announcing the Closing

Closing a practice should be handled in accordance with applicable laws. If possible, the dentist who is planning to close a practice should notify patients well in advance that the practice is closing. In most states, letters (See Sample Letters in Appendix A) to patients of record or an announcement in a community newspaper are ways in which a dentist might give advance notice of a closing. Notice of 30 - 60 days is sufficient for most patients and circumstances but, again, the laws of your state will control.

It is generally advisable once a closing date is determined, that no treatments be started that cannot reasonably be completed before the practice closes. However, when a dental practice must be closed rapidly or unexpectedly, it may be necessary to help patients currently undergoing extensive treatment find a new dentist who is willing and able to take their treatment to completion. Helping a patient locate and continue treatment with another dentist could avert an allegation of patient abandonment or other charge. It is also a compassionate, thoughtful way to discontinue a professional relationship.

With the patient's permission, the dentist should release treatment information or a copy of the patient's record to the dentist accepting the case. You may wish to request notification when the patient completes the treatment. This information could be useful should there later be an allegation of patient abandonment or malpractice.

A proper patient transfer from a dentist who must discontinue treatment prior to completion should involve at least these four items: 1) identifying a skilled practitioner who will accept the unfinished case; 2) providing that dentist accepting the patient with necessary clinical information so that he/she knows enough about the patient to continue or alter treatment, if necessary; 3) the patient agreeing to the referral; and 4) the patient actually submitting to the treatment in a cooperative fashion. Short of achieving all four, a dentist may unnecessarily be exposing himself to an allegation of patient abandonment, depending on applicable law.

Retiring dentists making a transfer of patients undergoing treatment would be prudent not to leave it to the patient to initiate the contact and make the appointment. With the patient's consent, the office should call and make the patient's appointment at the specialist or other dentist and send a copy of the record. This should be notated in the patient record.

Confirm with other dentist that the patient kept the appointment and is compliant. Record this and any comments from the dentist who accepted the case.

## Evaluating Patient Records

Patient records must be handled in accordance with applicable laws. However, in most states, a dentist is usually allowed to charge a patient a reasonable fee for duplicating and transferring records to another practice. When retiring, many dentists provide this service free of charge. Failure (or refusal) to release necessary information to another dentist for a patient's continuing care may be illegal and may be viewed as an unethical practice by your professional association. You should not refuse to release a patient's treatment information or records due to an outstanding payment.

Some dental practice acts or regulations issued by state boards of dentistry specify requirements for dental records. Generally, however, patient record keeping requirements are contained in laws or regulations that apply to health care professionals in general and also in more generic state legislative/regulations. Check with your state dental society for information on record keeping requirements in your state. To obtain a copy of your state dental practice act, contact either your state's board of dentistry, also known as the board of dental examiners at <http://www.aadexam.org> or go to <http://www.ada.org/ada/organizations/searchcons1.asp> to find a link to your state. Many states post their practice acts online and they are now easily accessible. (Hint: Google "[name of state] dental practice act."). Your state's laws actually govern whether a dentist must send originals. In most cases, the practice should only send copies of a patient's record to another dentist, and only with the patient's or their representative's (e.g. a legal guardian) permission. It is generally prudent to get this permission in writing. Make a note of where and when copied records are sent. Unless your state laws direct otherwise, original records should remain with the retiring dentist (or with the surviving spouse or his/her legal representative, since a dentist's estate can be sued years after a dentist's death) in accordance with a state's record retention laws.

## Transferring Records

Before transferring records to another practitioner, many states require that patient consent be obtained. A simple release form for release of the record to either the patient or another health care provider may be signed by the patient and become a part of the dental record. This release form, signed by the patient, should specify to whom the records are being delivered and identifying the records. Signing such a form is generally not required by HIPAA to send records to another health care provider, but in some states consent is required before releasing health information. Check with your state dental society about what is required in your state. Your professional liability insurance company may also consider obtaining and maintaining such a release a component of good record keeping.

General releases may not suffice for records containing HIV or other sensitive material. Most state laws prohibit the disclosure of HIV status test results to a third party without a specific written authorization by the patient or the patient's representative. Any information regarding health issues should be handled with caution and special regard for the patient's privacy. Even if appropriate authorization and consent is received, dentists and other health care professionals may be legally precluded from releasing HIV/AIDS records without specific reference to that information in the release. Some states have heightened confidentiality provisions for sensitive information, such as HIV status.

Typical elements of a valid general release include:

- Patient's name and identifying information
- Address of the health care professional or institution directed to release the information
- Description of the information to be released
- Identity of the party to be furnished the information

- Language authorizing release of information
- Signature of patient or authorized individual
- Time period for which release remains valid

As patients may not respond to simply an announcement of a practice closing, you may want to request that patients reply to you in writing by checking the appropriate response: 1) send records to the practitioner specified by the retiring dentist; 2) send records to the estate of the deceased dentist; 3) send a copy of the record to the patient; or 4) sent to another dentist as specified by the patient.

Considering that patients may procrastinate or not respond at all, the notice may specify what will be done if no response is received in a reasonable time (such as 30 days); however, you should make certain that your intended disposition of the records is in accordance with the laws of your jurisdiction. The notice should state where the records will be kept, i.e., with another dentist or with the retiring dentist or representative of his/her estate, and give instructions on how to obtain a copy.

To avoid having to deal with records for all your patients in a short time span, consider using multiple methods of notification of record handling options, such as a newspaper announcement, in-office handouts, letters, a message on the practice's voice mail system and/or a practice Web site. All notices should specify how patients may obtain copies of their records if they wish to transfer.

### **Record Handling During Sale of a Practice**

State law may also specify the obligations of buyer and/or seller regarding record ownership, maintenance and/or retention in the event of a practice sale. If the practice has been sold, the sales agreement itself may spell out the terms for record retention and access. The sales agreement clause related to patient records would typically permit the seller for a specified period of time to have access to the patient charts, records and x-ray file in connection with the practice sale transaction to allow review and making of copies for defense of malpractice litigation or to respond any inquiries from licensing or regulatory authorities.

When selling a practice, three main methods are available to the dentist for a transfer of patient records:

1. The dentist may choose to keep the original patient documents and provide the buyer with a copy of all the patient charts and radiographs. This method would provide the dentist with the best protection in the event of a future malpractice claim, since the old records would be maintained by the seller.
2. The dentist may choose to keep copies of all the patient charts and provide the original records to the buyer. This method may not give the seller the same liability protection as in the previous method.
3. The dentist could obligate the buyer, in the sales contract, to allow the seller access to the records in the event of need. The buyer is typically required to maintain these records for a set period of time after the sale. Further contract language regarding liability for records not maintained could be included. The disadvantage of such a transfer is that even with this provision, the buyer may inadvertently destroy or lose records or make access difficult. In evidence law, there is nothing better than the original document and, therefore, be sure it can be obtained in the event of a question or a professional liability claim.

Records should be stored in moisture and fire resistant containers. Check with your attorney or state dental association to learn the record retention requirements in your state and be sure to check with your risk management insurance carrier for additional information, recommendations and policy requirements.

State laws and participating provider contracts generally specify the time following the last patient visit that records must be maintained. There is usually a different requirement for the retention of records of children; these records must be kept for a certain period after the child reaches the age of majority. HIPAA also affects recordkeeping requirements for offices that are covered by generally requiring that such offices maintain patient records for six (6) years and two (2) years

after a patient's death. The dental office should have a records retention policy and all staff should understand it. The office's professional liability insurance company will likely have recommendations about retention.

In a multi-practitioner practice of any nature, determining the party responsible for maintaining the original patient record of any patient treated at the practice facility may be dependent on the type of professional corporation (PC) or structure of the practice. Unless the agreement specifies differently, the professional corporation would likely be considered the owner of the dental record, whether paper or electronic. This applies whether or not the owner was involved in the patient's treatment.

If the structure of practice is an office-sharing arrangement and the dentist is an independent contractor rather than practice employee, each dentist could be considered as practicing under a separate legal entity, such as a PC, limited liability company, partnership or sole proprietorship. Associate agreements, either for employee associates or independent contractors, should include language that provides for the associate's access to patient charts and ownership issues.

Oral health records may be preserved on microfilm or scanned in some jurisdictions. The great benefit of storing records with either of these methods is that they take up less space than paper records. However, prior to completely converting to microfilmed or scanned records, a dentist should consult with his/her own attorney and insurance carrier about the appropriateness of that decision.

Radiographs (x-rays) and the dental laboratory prescriptions of patients may be retained or destroyed in accordance with state law. In many states, the plaster study models of dentists can be destroyed pending risk management considerations.

### **Record Destruction**

Patient records should always be maintained in accordance with state retention laws. For those inactive patient records (beyond any applicable Statute of Limitation) that will not be transferred or returned to patients, a more secure way of eliminating these unwanted records generally involves shredding. There are professional record destruction services available to do this for you or you could rent an industrial-grade shredder and destroy the records yourself. Small paper clips and staples generally do not have to be removed prior to professional shredding.

A professional record destruction service should sign your confidentiality agreement (or HIPAA "Business Associate Agreement," if applicable) and you should seek to require them to agree to indemnify you and hold you harmless in the event of a breach in confidentiality. Most services issue a certificate of destruction.

NAID (National Association for Information Destruction, Inc.) claims that it is the international, non-profit trade association for the information destruction industry. Membership includes companies (including suppliers) and individuals involved in providing information destruction services. See <http://www.naidonline.org/members.html> for further details if you need a commercial shredder firm. You might also contact larger health care providers in your local area, such as a hospital, for a recommendation for a record destruction company.

**Caution:** Do not burn patient records containing radiographs as the heat could release dangerous metals. Silver recovery by a professional recovery firm that pays you for the silver content from destroying large numbers of old x-rays might be a better option. Check a phone directory or with your state or local dental society for a silver recovery firms or certified waste haulers.

Paper re-cycling is not a good option if you have to get rid of inactive paper dental and business records in order to close a practice. Under most circumstances, recycling companies merely collect then sort paper. The collected paper is likely to be bound and sold to the highest bidder weeks or months later (even years later). There is no guarantee of confidentiality and there is no way to ensure just when the paper, potentially containing confidential or sensitive information, was destroyed.

Re-cycling without destroying patient records for a retiring dentist closing his/her practice and improperly disposing of the records might be viewed as negligent by the court in the event of an allegation of breach of confidentiality or in the case of a federal complaint to the Department of Health and Human Services Office of Civil Rights (for a supposed HIPAA violation by a covered entity) as an illegal practice under the Act. Additionally, it may expose your patients to identity theft. In any case, re-cycling without documentation of destruction is an example of poor risk management.

Always insist on a certificate of destruction. Furthermore, make sure that there are no sub-contractor companies involved unless they have also agreed in writing to adhere to the privacy policies of the practice.

### **Retention of Other Business Records**

In addition to being familiar with patient recordkeeping requirements, a dental office also needs to retain other records. These records also may have statutory retention requirements. The proper retention period will vary from state to state and, maybe from practice to practice. Here is a typical schedule of retention periods. Yours may be different. Consult with an attorney to establish your own schedule.

## Business Record Retention<sup>i,ii,iii,iv,v</sup>

**Retention period is the number of years from the date of the tax return filed.**

**All information is general only and not offered as legal advice.**

The proper retention period will vary from state to state and, maybe from practice to practice. Here is a typical schedule of retention periods. Yours may be different. Check with your personal advisor, such as accountant, attorney or professional liability insurance company to establish your own schedule. State and federal laws may apply, in addition to the state dental practice act.

Record Type	Retention Period
<b>Tax &amp; Financial Files**</b>	
Accounts payable ledger & schedule	7 yrs
Accounts receivable ledger & schedule	7 yrs
Audit/accountant annual report	Permanently
Bank statements (monthly)	3 yrs
Capital asset records	Permanently*
Cash receipt journal	Permanently*
Checks (cancelled – see exception below)	7 yrs
Checks (cancelled for important payment – i.e. taxes, purchases of property; file with transaction)	Permanently
Contracts and leases (expired)	7 yrs
Contracts, mortgages & leases (still in effect)	Permanently
Deeds, mortgages & bills of sale	Permanently
Deposit books & slips (duplicate)	3 or 6 yrs*
Depreciation schedules	Permanently
Financial statements (yearly)	Permanently
General ledgers	Permanently
Income tax returns, worksheets and related documentation	Permanently
Insurance policies (expired)	3 yrs
Insurance records, current accident reports, claims, policies, etc.	Permanently
Inventory of products, materials & supplies	7 yrs
List of accounts (assets, liabilities, revenue, expenses, etc)	Permanently
Petty cash vouchers	3 yrs
Retirement plan records (documents, investment records, allocations)	Permanently
Vouchers for payments to vendors, employees, etc. (includes allowances & reimbursement of employees, etc. for travel & entertainment expenses)	7 yrs
<b>Employment Records</b>	
Applications (not hired)	3 yrs
Personnel records (after termination)	7yrs
Payroll records, taxes & summaries	7 yrs
Time sheets, cards or time clock	7 yrs
Training manuals	Permanently
Workman compensation records	5 yrs
<b>Patient</b>	
Daysheets, schedule	7 yrs
Patient billing/payment or fee statements	7 yrs
Third-party insurance claims, records & correspondence (EOBs)	7 yrs
<b>Other**</b>	
Accident reports/claims (settled cases)	7 yrs
Controlled substance copy	2 yrs
Correspondence, routine with patients or vendors	2 yrs
Correspondence (legal or important)	Permanently
Legal agreements (partnership, associateship)	Permanently
Medicare billing records	7 yrs
OSHA records (log and summary)	5 yrs past the year to which it pertains

## Dental Equipment, Supplies & Medicaments

An estimation of the dental equipment's salvage or resale value can vary depending on the appraiser or on unique circumstances. Age, serviceability, difficulty of removal, and compatibility with existing systems can be principal determinants of the dollar value of salvaged dental equipment. In many cases, a professional dental equipment appraiser or a reputable supplier can provide independent estimations about the worth of particular equipment.

The ADA's Council on Dental Practice distributes a *Directory of Dental Practice Appraisers and Brokers*. This publication contains the names, locations, description of services and other background information for professional valuers. (**Note:** The descriptive information in the *Directory* is supplied by those who are listed). None of the information is independently verified for accuracy or correctness by the Council. Individuals and companies named in the publication have paid a fee to be included. The publication is offered as a service to members. A listing in the *Directory* should not be viewed as representing an endorsement by the Association. The *Directory* is available online free <http://www.ada.org/prof/prac/tools/appraisers/search/searchstart.asp>. Non-member dentists and others must pay a handling fee for mailing a hard copy of the publication.

There is some demand for used dental equipment in "excellent" condition. Typical purchasers might include new dentists who are setting up their first practice; established dentists adding a treatment room; international dentists; or dental supply companies maintaining an inventory of used equipment. Used dental equipment that is in "good" working order can sometimes be donated to a local organization providing dental services to children, the homeless or to the poor. Contact your local or state public health department. A dentist or his/her estate could receive a tax credit for donating dental equipment for charitable use. Consult your accountant who will likely advise you to have the equipment properly appraised before taking a tax credit.

Dental equipment that is very old or that is in "poor" working condition may have no value. A scrap metal dealer might be interested if the recycle value of the metal or other components exceeds the cost of disconnecting and disposing of the old equipment.

A surviving spouse should also see a tax accountant or lawyer to determine their full tax liability. Federal law requires that an estate tax return be filed within nine months of death. Final business taxes for the professional corporation, partnership, limited liability corporation or sole proprietorship must be computed and paid. If the practice is closed, the legal entity should be properly dissolved, according to state law.

Caution should be exercised before selling or donating dental supplies, especially chemicals and medicaments. Supplies that have reached or are near the end of their shelf life could be unsafe or ineffective if used. Any expired and or opened bottles, containers or packages often have uncertain content and should not be considered for donating. If unopened, some supplies might be returnable for a credit or refund. Check with your supplier.

Environmental laws in your area may apply to the disposal of various solvents and disinfecting agents that can sometimes be found in a dental office. ADA Guidelines on Amalgam Accumulations in Dental Office Plumbing are available at [http://www.ada.org/prof/resources/positions/statements/amalgam\\_plumbing\\_guidelines.pdf](http://www.ada.org/prof/resources/positions/statements/amalgam_plumbing_guidelines.pdf). [http://www.ada.org/prof/resources/pubs/jada/reports/report\\_radiography.pdf](http://www.ada.org/prof/resources/pubs/jada/reports/report_radiography.pdf). Again, check with your attorney, state society or local governmental disposal authority for the requirements in your area.

State regulations may provide instructions regarding disposal of film-processing solutions and lead foil from the film packet. Fixer solutions may be considered hazardous waste because of their silver content and should be placed in containers and transported for recycling or to disposal sites. The EPA recommends that lead foil be disposed of in accordance with local regulations.<sup>vi</sup>

It may be against the law, for example, to discard particular chemicals into a sink or toilet, or to pour them over a field or directly into a sewer. Straight alcohols, ethers, and peroxides, for example, are

considered flammable and should not be added to the public water system because of the possibility of explosion.

Additionally, many communities have implemented programs concerning the appropriate disposal of chemical wastes that may include recommendations about silver, mercury and dental amalgam particles.

In some cases, disposing of hazardous chemicals can require the services of a licensed hazardous waste hauler. Read the label on containers carefully and observe the precautions and instructions. The local office of the Environmental Protection Agency (EPA) or your city or state government may be able to give you additional disposal information. For additional information about questions to ask a dental waste recycler and a directory, go to [http://www.ada.org/prof/resources/topics/topics\\_amalrecyclers.pdf](http://www.ada.org/prof/resources/topics/topics_amalrecyclers.pdf).

**Material Safety Data Sheet File:** Specific information about the chemicals, medicaments, or disinfecting agents deemed to be hazardous and present in a particular dentist's office, is available in a file which OSHA (Occupational Safety Health Administration, a regulatory agency of government) requires dentists and other users to maintain, called the material safety data sheet (MSDS) file.

The MSDS file gives information about a chemical's characteristics, uses, routes of exposure, handling, first aid measures, spill and leak procedures, storage requirements and safety precautions. An MSDS sheet contains instructions about how to properly discard expired, or partially used chemicals. Furthermore, the manufacturer's business telephone number generally appears. Call the company if you have questions. (Note: OSHA now allows a dentist, under certain conditions, to maintain this file electronically such as computers, microfiche machines, the Internet, CD-ROMs and fax machines.)

**Undistributed Medications:** It is unsafe or illegal practice for non-dentists to sell certain undistributed medications in the office, such as sample drugs; or to take these items home for personal use.

Medicaments for direct patient usage (pills and powders) are sometimes stored in a dentist's practice. Some may be controlled substances—often narcotics—that are stored in a locked cabinet or in a safe. You should know that there are strict reporting laws governing the distribution and/or possession of controlled substances. The White House Drug Policy ([www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov)) offers the following guidelines for disposing of drugs:

- Take unused, unneeded or expired drugs out of the original containers and throw them in the trash.
- Mixing drugs with an undesirable substance such as coffee grounds or kitty litter, and putting them in impermeable, non-descript containers such as empty cans or sealable bags, will further insure the drugs are not diverted.
- Flush prescription drugs down the toilet only if the label or accompanying patient information specifically instructs doing so.<sup>vii</sup>

**Dental Managed Care** If the practice participates in a dental managed care plan, consult the insurance company prior to closing to determine the best timing with any scheduled payments. The use of advance payment or certain quarterly payment distributions could create accounting complications or create a situation where significant monies are owed back to the plan.

**Disinfecting Dental Equipment:** Dental instruments (the hand tools a dentist uses on patients), environmental surfaces such as counter tops, and some equipment should be evaluated for disinfecting or sterilizing before they are donated, sold or destroyed. Proper disinfecting requires specific training. A surviving spouse or family member is generally unfamiliar with proper disinfecting techniques and should consult dental team members about this task.

If the practice's dental assistants are still available, they could help sanitize the office and equipment. Otherwise, a colleague and his/her dental assistants might assist.

**Hazardous Wastes:** Sharps may include needles, scalpels, dental broaches, files, reamers and burs. There is the danger of puncture wounds from these items if placed into the garbage. Even if sterilized, these items should only be discarded into a puncture-proof container that is properly labeled.

**Bloody Wastes:** It is unlikely that a spouse closing a practice will need to deal with discarding bloody patient dressings, swabs, etc. However, if you do, please note that the disposal of infectious medical wastes needs special training. The local dental society or a community sanitary district garbage hotline, if one exists, may be helpful if it is necessary to deal with bloody wastes.

The Centers for Disease Control and Prevention (CDC) issued “Guidelines for Infection Control in Dental Health-Care Settings – 2003.” This report consolidates recommendations for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control in dental settings. Applying these standard precautions requires a professional. (Information is available at <http://www.cdc.gov/OralHealth/infectioncontrol/guidelines/index.htm>)

## Professional Notifications

The Drug Enforcement Agency (DEA) in Washington, DC has enforcement responsibility for controlled substances (<http://www.DEAdiversion.usdoj.gov>). Any practitioner desiring to discontinue business activities with respect to controlled substances must notify the nearest DEA field office in writing. Along with the termination of notification of registration, the practitioner should send the DEA Certification of Registration and any unused Official Order Forms (DEA Form-222) to the nearest DEA field office.<sup>viii</sup>

In order to change a dentist’s address or update other information that is kept on file, the DEA should be contacted whenever a dentist moves to a new location, ceases practicing or dies. The agency should also be contacted prior to a non-dentist removing or discarding suspicious pills or powders which are believed to be controlled substances. The DEA will advise on how to dispose of any narcotics or other dangerous drugs, registration certificates, or items such as prescription pads, letterheads and certain records. There could be state requirements as well if there is a State Commissioner of Narcotics and Dangerous Drugs. You should therefore, check locally. Pharmacies where patients most often fill the dentist’s prescriptions should be notified of the dentist’s practice closure.

Dentists may be required by state law to inform the dental board (<http://www.aadexam.org/>) or other professional regulators about an incapacitating condition affecting their practice of dentistry. The retiring dentist should determine if they plan to retain their licensure (most do) and, if doing so, be familiar and comply with continuing dental education requirements.

The practice insurance representative, accountant and attorney should be informed about the closing. These professionals are valuable sources of information and guidance about common business situations and decisions connected with closing a practice.

If the retiring dentist is a general dentist, announcements should be sent to specialists who normally receive referrals. Vice versa, if the retiring dentist is a specialist, referring colleagues should be informed. Any health care referral services, such as through a local hospital, public health office or medical/dental society, should be informed of changes.

If advance notice of the closing can be given, it may be useful to inform the landlord about the pending vacancy so that he/she can review the lease with the dentist and decide related matters such as whether or when to disconnect the gas or electric service, etc. Business leases or other interests in real estate must be addressed and resolved. Seek advice from an attorney.

The local dental society and the State Board of Dental Examiners (<http://www.aadexam.org/>) should be notified as well about an incapacitated or deceased dentist. See a listing of state (constituent) dental societies in Appendix D. Some societies have information that can help you locate temporary professionals during an emergency. Many local dental societies have information about assistance to impaired dentists through their Well-Being Committee (<http://www.ada.org/prof/prac/wellness/index.asp>).

Hiring a temporary dentist following the disability or death of the dentist can be a way to keep the practice active until a sale occurs. An active practice generally has a higher resale value than an inactive one. Keep in mind that state law may limit non-dentist ownership even in such circumstances. For more information on ownership issues, go to [http://www.ada.org/prof/advocacy/issues/ownership\\_practices.pdf](http://www.ada.org/prof/advocacy/issues/ownership_practices.pdf) or contact your state dental society.

A common question is, can the hygienist continue seeing patients before a replacement dentist is in the office? As of this writing, forty-one states plus the District of Columbia permit general supervision of dental hygienists in dental offices. The distinguishing feature of general supervision is that the dentist need not be present when patient care is provided. Most of these jurisdictions require, as a condition of general supervision, that the supervising dentist examine the patient first, develop a treatment plan, issue a written work order and/or evaluate the hygienist's work within a fixed period of time. Other restrictions may also apply. It would be best to obtain legal advice if there is no temporary or a permanent dentist on hand to provide supervision.

**What Is A Mutual Aid Agreement?** A “mutual aid agreement” is a formal contract with colleagues whereby in the event of the sudden illness, injury or death of a dentist-signer to such an agreement, the other signers promise to temporarily cover for the stricken colleague until either his/her recovery, or up until the time when a deceased dentist's practice is sold. The ADA has a booklet online ([http://www.ada.org/prof/resources/topics/dentalpractice\\_mutualaid.pdf](http://www.ada.org/prof/resources/topics/dentalpractice_mutualaid.pdf)) about how a dentist can organize a mutual aid group. You may also contact the ADA by calling the toll free number, ext 2895; direct dial 312-440-2895; or e-mail [dentalpractice@ada.org](mailto:dentalpractice@ada.org).

A non-paid volunteer dentist working temporarily in the office of a recently deceased dentist as a courtesy in order to complete cases needing only a single visit (e.g. cementing a completed crown, or delivering a finished denture or partial) if asked by the patient, should sign a claim form for a billable insurance service, using his/her own name and information, as the dentist who performed services. The ADA claim form allows one field for the billing entity and a separate one for the dentist performing the services (they may not be the same). This would allow the payments to be sent to the billing entity, such as a deceased dentist's practice.

Other notifications about closing the practice could be made to the dentist(s) who have routinely accepted emergencies from the practice during the dentist's absence. Similarly, dental laboratories and certain suppliers may need to be included in any general notification about the closing of the office or of the changed status of the dentist.

## Revising Your Insurance Portfolio

When closing a practice, a dentist should also review all insurance policies and terminate those that are practice and/or income-related. Disability income, disability overhead expense, professional liability insurance and practice interruption insurance should be terminated effective with the date of retirement. You may also wish to review with your financial consultant the amount of any term life insurance you are still maintaining.

Policies covering workers compensation and employee benefits should be terminated as of the last day of work for your employees unless applicable law or the terms of employment dictate otherwise. Policies covering the contents and equipment of the dental office as well as business liability exposures should be terminated when the office is sold and/or closed (such as when a lease is lost).

In most, if not all cases, if you have paid premiums for periods extending beyond the date the policies are terminated, your insurance company will refund the unearned premium. To cancel your policies, it is generally necessary to submit a cancellation request in writing.

## Special Considerations for Professional Liability Insurance Policies

Even after retirement, you will continue to be exposed to the risk of a professional liability allegation. Depending upon the state in which you were practicing, the statute of limitations for the filing of professional liability lawsuits may continue for many years. The statute may be even longer for treatments provided to patients who were minors.

While your professional liability insurance policy should be canceled effective with the date of your retirement, subject to applicable law, you should carefully retain your policy with your important records so that it is easily accessible. In the event that you learn a former patient is accusing you of malpractice, you will need to refer to your policy so that you can notify your insurer and seek its assistance in defending you from the patient's claim. Since it is also possible for a dentist to be sued for malpractice posthumously, the executor of your estate should be able to easily locate the policy. You may also wish to include the address and telephone numbers of your insurer and insurance agent among your estate documents and to update this information periodically.

**Occurrence Policies:** If you have been insured under a professional liability insurance policy written on the occurrence form, you need take no action upon retirement other than to notify your insurer and request a refund of unearned premium. You and your estate will be protected up to the limits of the policy for any claims brought against you after your retirement no matter when they are reported.

**Claims-made Policies:** If you have been insured under a claims-made professional liability insurance policy, it is essential that you secure an extended reporting endorsement, which is commonly called "tail coverage." This endorsement will provide you with continuing protection if you are sued in future years for a treatment rendered while the claims-made policy was in-force. In many cases, insurers issue this endorsement at no cost when retirement is due to a permanent disability or when it occurs after a specified age (e.g., 59) and/or providing that you were insured under the policy for a specified period of time (e.g., five years).

In the event of the death of a dentist who was insured under a claims-made policy, it is also advisable that a dentist's heirs consider securing an extending reporting endorsement as an estate may be vulnerable if the dentist is sued posthumously for malpractice. Most insurers provide the endorsement for no cost upon the dentist's death.

Whether the extended reporting endorsement is secured upon retirement or the dentist's death, it must generally be requested within a limited period of time, such as 30-days, following the date on which the claims-made policy was terminated. After this period of time, it will probably not be possible to purchase the coverage either from your former insurer or from any other company.

Depending upon the insurance company, it may be possible to purchase higher limits of liability on your extended reporting endorsement than were carried on the policy itself. If you carried relatively low limits (e.g., less than \$1million/\$3 million) you might consider purchasing additional protection. A modest one-time premium expenditure may give you additional peace-of-mind during retirement.

## Office Overhead Expense Insurance

Carrying office overhead expense insurance could provide a disabled dentist with substantial protection. Unlike disability insurance, which can be expensive, overhead expense insurance is a flexible, affordable solution for small business owners, including dentists.

With office overhead expense insurance, you are reimbursed for certain monthly office expenses (such as rent or mortgage payments, utilities, a replacement dentist's salary, employee salaries and benefits, student loans and practice loans) if you are disabled. It's an influx of cash that buys time—time to recover and return to full-time clinical work, or time to weigh all the options before making a decision about selling.

Features of a good office overhead expense insurance policy:

- An “own occupation” definition of disability
- Reimbursement of all practice-related expenses, including depreciation and debt servicing as well as the salary of a replacement dentist
- A high maximum benefit that can accommodate future practice growth as well as a waiting period that is consistent with the practice’s cash flow
- Benefits that last at least one year and which are also payable in case of partial disability.

## **Contacting the Social Security Administration/ Veterans Affairs**

A dentist at retirement age or one who is disabled may be able to apply for Medicare coverage or be entitled to benefits from the Social Security Administration (<http://www.ssa.gov/>). You should contact the social security office in your state for information.

A surviving spouse upon the death of the dentist should contact the nearest [Social Security Office](#) about Social Security benefits and if applicable, the nearest [Veterans Affairs Office](#). In either case, you may need the dentist’s Social Security Number (Veterans Affairs Number), a certified copy of the death certificate (and birth certificate), and proof of marriage or relationship.

## **Keep Your Association Informed**

As stated previously, call your [state or local dental society](#) regarding 1) plans to retire and close the practice; 2) whenever a long-term illness occurs affecting a dentist’s ability to practice; or, 3) following the death of a dentist. Some local dental societies offer assistance with temporary coverage in the office or have knowledge of local resources.

ADA members who retire from the practice of dentistry and do not move into another dental occupation become eligible for retired membership the year following retirement. An affidavit of retirement should be submitted to your state dental society (or to the ADA, if you are a direct member). Retired members pay 25 percent of full dues/assessment ([http://www.ada.org/ada/join/joinada\\_faq.asp](http://www.ada.org/ada/join/joinada_faq.asp)).

## **Handling Staff**

Retiring dentists should retain adequate staff even as they decrease their workload in anticipation of retiring and closing the practice. If you are the retiring dentist, you may want to tell the staff about the closing 90 or more days in advance, earlier if necessary or if required by law. Offer incentives that encourage staff members to stay until the last day. However, since some valuable staff members may still leave beforehand, a retiring dentist needs to ensure that essential personnel will remain with the practice up to the day of closing, even if it means hiring temporary employees.

In many towns, there are temporary employment agencies, which may be able to quickly send over support staff. Some of these agencies may even be able to help you find temporary professional help, including trained dental assistants, hygienists or dentists. Consult a directory for a temporary help listing, do an online search or ask the nearest dental society or a colleague to recommend an agency.

Your normal manner of following up inquiries from insurers and patients concerning payments can continue when there is an adequate number of staff members on hand to handle these functions. If collections are interrupted because of a lack of staff, this could mean the loss of considerable monies from a dentist’s retirement fund. For those planning to retire, consider keeping the business checking account open for 90 days following the closing in order to process late transactions.

Another reason for having staff on hand up to the closing date is that this allows the dentist more time to organize the transition and suffer less stress. The dentist will be able to provide the same level of high quality service, even on the last day, if other details are continuing to be handled by the staff.

If appropriate, following the closing of the practice, thoughtful expressions of appreciation such as thank you cards, flowers, candy, or modest gifts could be sent to those businesses that have supported the dental office over the years. Staff members should be included in any expression of gratitude. Severance pay could help ease some of the financial stress that a dental team member might ordinarily experience before finding another job. The amount of the pay could be based on the number of years of service. Gifts, letters of appreciation or a truthful reference are other ways to convey your appreciation.

Be sure that the staff understands about pay and benefits prior to the last day, as a dentist may have responsibilities for staff retirement or health insurance plans.

Long before it may be needed, it may be prudent for a spouse (or trusted business associate or advisor) to be given check writing authority (a signed card on file with the practice's bank) and access to the safe deposit box of the practice. If a dentist dies unexpectedly or suffers a serious injury or illness that will create a long-term (or permanent) business interruption, then the spouse or agent of the dentist can pay bills while making preparation for closing or selling the practice.

**Office Security:** If the practice indeed is to be closed and not sold, you may wish to get some advice from the Internal Revenue Service (IRS) which maintains online information on closing a business. (Go to <http://www.irs.gov/businesses/small/article/0,,id=98703,00.html>). In addition, a spouse or agent could begin the closing process by first evaluating office security. Consider whether to change the external door locks and entry security code or the computer password. Protecting everyone's best interest, including your own if you are the surviving spouse, may be up to you. Be aware of the feelings of others, but don't allow sentimentality to interfere with good judgment.

Some staff members might take offense at suddenly having someone else take charge. However, under the circumstances, the spouse will indeed need to assume responsibility for making decisions. In a crisis, almost everyone is looking for leadership.

With help from this guide, there is no reason why a spouse couldn't successfully transition a practice following an emergency.

Prescription pads, partially used or empty cylinders of anesthetic gases (nitrous oxide), backup computer files, casting gold, signature stamps, cash, business stationary, diplomas & professional licenses, and business and patient records should all be accounted for and/or destroyed per regulation.

If you are the surviving spouse, until the practice is closed or sold, it may be advisable to:

- Do all the banking and check-writing yourself.
- Allow only your own name on all bank accounts.
- Request final bills from all suppliers. Examine each bill closely.
- Be suspicious of a vendor bill that is new or of an expense or staff bonus that you cannot verify.
- Ask the accountant to do an audit to determine the debts and credits of the practice. A lien could tie-up sale of the practice and result in delaying or even losing a potential buyer.
- Collect **all** keys and change password(s) so that only you control access to the building (or office suite) and to the practice management system.

### **Exceptions to Ownership / Operation Restrictions upon a Dentist's Disability or Death**

At this writing, at least twenty-three (23) states — California, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Maine, Missouri, Montana, Massachusetts, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, and Vermont — permit the estate or spouse of a deceased or incapacitated dentist to own or operate a dental practice, or to employ a dentist. Montana, for example, limits the period of such ownership to 12 months and Ohio limits it to 90 days; however, some states do not specify any time limit. New Mexico allows spouses or hygienists to own the dental practice for up to a year after the death of

the dentist. These laws can and do change, check the ADA Web site from this link [http://www.ada.org/prof/advocacy/issues/ownership\\_practices.pdf](http://www.ada.org/prof/advocacy/issues/ownership_practices.pdf) or call your state dental society.

Unless allowed by state law, the spouse should not begin releasing recently repaired or newly made dental partials and full dentures or crowns directly to patients. Delivering or returning dental appliances requires a valid dental license. If no temporary dentist is helping the practice, a better way to return or deliver these items is to ask patients to name a dentist to whom the appliance and appropriate records should be sent.

As soon as possible following the death, impairment or serious illness of the dentist, hold a staff meeting to make plans and assign responsibilities. Decide, for instance, what will be said to patients about what has happened to the dentist or why the practice is closing.

Find out if the practice has a protocol whereby emergency and/or scheduled patients are referred to particular dentists in the owner's absence.

Avoid making blanket promises to patients or staff, since as you begin to understand more about how the office works, you could come to regret making promises that you cannot keep.

For example, after a dentist's death, personnel records may be needed to verify a promised salary increase claimed by a staff member. In **Appendix A: Sample Letters**, there is a script that could be used to inform patients about the sudden illness or death of the dentist. This could help the practice deal with any unexpected dental emergencies, even in a crisis.

## **Collecting Outstanding Debts**

It may be difficult to collect outstanding payments from patients following the retirement, long-term illness or death of a dentist. Slow paying patients may view the dentist's changed situation as an opportunity for them to reduce their monthly payment amount or to stop paying their dental bill altogether. If affordable, it may be advisable to simply write off some or all of these bad debts. It is advisable to balance all accounts, if feasible. To avoid later claims, clarify any accounts in which the patient has prepaid for services or is on an installment payment plan.

If that is not possible, a spouse or agent may need to evaluate whether to place large delinquent accounts with an outside collection agency. Ask yourself whether a particular debt is significant. Check to see how well the practice documented the financial arrangements, patient communications and billing and payment history. It may not be worthwhile trying to collect old debts using a collection agency if you lack adequate reason and documentation. Consult your attorney, get professional collection advice and then proceed carefully.

## **Marketing the Practice**

Ideally, the best circumstance would be to have ample time and many potential buyers. Realistically, the ideal window from listing the practice for sale to closing is generally no more than four to six weeks. However, by the second or third week in a small town, many patients are already aware of the dentist's situation and may be beginning to focus on a solution of their own.

A few patients will begin to ask questions of the staff in order to decide whether to remain in the practice or to leave while they still have confidence that they can obtain their dental records easily. If there is too long a delay for the sale, many patients might simply drift to the nearby colleague by default. Acting quickly is important because a future earnings stream is the most important thing a dentist receives when he/she purchases a practice and it has a major impact on the practice's value.

This is the point at which a good strategy to quickly sell the practice is essential. The seller will need tax returns, patient information (such as number of active patients), and current and past productivity records of the practice. A buyer typically might want to know about agreements with others who provide services to the practice and about personnel information (salaries and job descriptions).

There are many ways and sources to locate buyers including: word of mouth; dental schools; dental placement services; national, state or local dental societies; dental supply companies; dental consultants or brokers; and either print or online advertisements. Recent dental school graduates and dentists who are associates or leaving the military are often candidates.

Since showing a practice can be stressful, you may prefer to have a professional broker with pre-qualified candidates handle the sale. If you wish to use a professional to assist in the sale, the ADA offers an online resource — the *Directory of Dental Practice Appraisers and Brokers*. The *Directory* lists professional dental practice appraisers and valuers and is available at no charge online at <http://www.ada.org/prof/prac/tools/appraisers/search/searchstart.asp>. Be sure that the potential broker will undertake a complete marketing plan that can get results (including mailings, contacting new dentists through a local dental school and to local & state dental societies).

Without an apparent succession plan, patients and staff will likely abandon the practice quickly leaving no option but to close the practice.

## **Hospice and End of Life Decision Making**

A hospice is not so much a place as it is a concept of care. The basic concept is of a facility or service(s) that provides comfort and support to patients and their families when a life-limiting illness nears its terminus and a sick individual no longer responds to cure-oriented treatment.

The goal is to provide high quality care, pain management and family support that neither prolongs nor hastens the death of the patient. In 2005 in the United States, more than 1.2 million individuals and their families received hospice care. Hospice is the only Medicare benefit that includes pharmaceuticals, medical equipment, twenty-four hour/seven day a week access to care and support for loved ones following a death. Most hospice care is delivered at home. Hospice care is also available to people in home-like hospice residences, nursing homes, assisted living facilities, veterans' facilities, hospitals, and prisons.<sup>ix</sup>

Hospice programs exist in many communities across the country. The volunteer and professional staff of these programs and facilities are skilled in dealing with the emotional, social and spiritual impact of disease or serious injury on the patient and the family.

A typical hospice program is less than six months, in order to receive the Medicare Hospice Benefit. Keep in mind that a terminally ill individual's life expectancy could vary from average life expectancies for other patients with similar conditions.

Choosing a hospice for a terminally ill individual is not an easy decision. Should it be necessary to use a hospice facility rather than hospice in the home setting, recommendations for a particular hospice might come from the hospital, nursing home, physician or nursing staff, or from a friend. To narrow the selection, consider obtaining appointments that allow you to visit several facilities to inquire of staff how they provide for the terminally ill and for their family. Another source for locating a hospice program is your city, county or state department on aging.

In general, the hospice should at least provide residents with the services of a registered nurse, social worker and a chaplain. This multidisciplinary approach should be augmented by pain management specialists, the patient's own physician and bereavement counselors who are sensitive to the welfare of the family or spouse.

## **Do Not Resuscitate (DNR) and Other Advance Directives**

The purpose of an advance directive is to let others know what kind of care is desired if an individual cannot speak or make those for himself/herself. Many hospices will ask you about a Do Not Resuscitate (DNR) directive. The directive usually spells out the type of care a dying individual wishes or conversely which care is not desired.

**Durable Power of Attorney:** The durable power of attorney (DPA) is an advance directive and legal construct (in most states) that in effect authorizes another individual, when an individual is unconscious or otherwise unable to speak for themselves, to legally decide their medical options. It is sometimes referred to as a Health Care Power of Attorney. Health care decisions include the power to consent, refuse consent or withdraw consent to any type of medical care, treatment, service or procedure.<sup>x</sup>

**Living Will:** A living will is a third type of advance directive that allows an individual to predetermine the kind of care they desire when they cannot speak for themselves. However, there is no transfer of medical decision-making to a designated individual in this type of arrangement.

The DNR order, the durable power of attorney and the living will can each be revoked by a patient who is of sound mind and who follows the requirements of state law. A personal attorney, many charitable organizations and various software programs can supply the legal documents which could help an individual create a valid advance directive. State laws on these issues vary, as can a hospital's or other health care facilities' policy on acceptance.

## **Dealing with Grief upon a Dentist's Disability or Death**

Manifestations of grief, according to experts, can range from physical responses to various emotional responses such as unexpected crying episodes, guilt and sleep disruption; even to anger that a loss causes pain; or that despite our valiant efforts the deceased left us anyway. 'Complicated' (unsuccessful) grieving can be catastrophic for some individuals and lead to suicidal ideation or behavior.

Individuals who have previously experienced great loss may be more accepting of another close loss. They, in effect, have learned how to grieve and recover. Similarly, deeply spiritual individuals and individuals who have cared for a loved one through a long illness might be more accepting of death. These individuals have worked out their grief in advance. Most of us need love and support to achieve successful grieving. Thanatologist, Elizabeth Kubler-Ross' 1969 book "On Death and Dying," (Macmillan Publishing Company) is considered by many experts in grief counseling as a seminal publication in grief theory. Dr. Kubler-Ross' Five Stages of Dying model is well-known---though not without some controversy. In her theory the dying and those who experience the death of a loved one go through the following stages:

- Denial and Isolation
- Anger
- Bargaining
- Depression
- Acceptance

Whether the dying or an individual who experienced a significant loss go directly from one stage to the next; via a circular path; or whether there are intermediate "stages" as critics of Kubler-Ross' theory argue, may be considerations best left to researchers & clinicians than to lay persons using the book simply to get a grip on their own feelings.

At some point the survivor may feel sorrow, anger, loneliness, shame, anxiety or guilt. Don't be hurried to the next "stage" by well-meaning friends or acquaintances pushing you to get on with your life. Grief takes time---as much as two years or even longer following traumatic loss---and is highly personal.

## **Survivors Getting Help**

It may be important for a stressed-out surviving spouse to see their physician. Visiting a physician after the death of a loved one allows the doctor to check the surviving spouse's general health, look for signs of severe stress or emotional disorder, and provide appropriate care or referral to a grief counselor (usually a psychologist).

NOTE: If you as the surviving spouse are experiencing shortness of breath or tightness in the chest or throat, these could be potentially serious symptoms and you should seek medical care soon.

Speaking with an experienced, professional grief counselor could be a way for a surviving spouse (or for family members) suffering severe emotional or physical symptoms to allow themselves, under supervision, to appropriately grieve and begin recovery. While such counseling is not commonly needed, traumatic loss could produce such severe emotional stress that an individual might benefit from counseling.

If the staff is suffering in the same manner from traumatic loss, you may want to arrange grief counseling for them as well. Group sessions with a local psychologist could help severely affected employees deal with their grief; with uncertainty about continued employment within the practice; or ways to endure a stream of potential buyers coming through the practice and the changes such a sale might bring.

A surviving spouse who works outside of the spouse's dental practice might have an employment benefit, such as an employee assistance program, that includes access to confidential employer-paid grief counseling. State and local government generally have grief assistance programs that are available through the local equivalent of a department of mental or public health, or of human services. Some of these state agencies offer burial expense assistance to needy applicants (e.g. under provisions of the Medicare program).

National charitable organizations associated with severe diseases, conditions or injuries often provide counseling service to affected family members via a local support group. Ask your physician, community hospital or a social worker to help you locate a nearby support group or you may be able to find the nearest location in a local telephone directory or through an internet search. For bereaved persons of faith, counseling from a priest, rabbi or minister might provide special comfort following the death of the family member. Most every religious establishment---church, mosque or synagogue provides faith-based counseling.

## Appendix A Sample Letters

It is assumed that these letters will be printed on letterhead which contains the practice/dentist name, address and phone number necessary for a patient to contact you. Otherwise, be sure to include contact information, including days and time available, enabling patients to reach the practice.

### Sample Newspaper Announcement About Closing the Practice

The dental office of Dr. \_\_\_\_\_ located at \_\_\_\_\_ phone number \_\_\_\_ is closing on \_\_\_\_ (date)\_\_\_\_ due to \_\_\_\_\_ (give a reason, if possible)\_\_\_\_. We thank you for your patronage. It has been our pleasure to serve your dental needs.

At your request, copies of the pertinent information from your record can be made available to a dentist of your choosing. If you wish to make a request regarding your patient record, please contact the office before the permanent closing day, as we shall need your written authorization to make your records available to another dentist. After that day, you will have to direct your inquiry about the record to \_\_\_\_\_ (name of dentist or record custodian)\_\_\_\_, located at \_\_\_\_\_.

### Sample Phone Script Telling Patients About the Sudden Illness or Death of the Dentist

Telephone Caller: This is \_\_\_\_ (your name)\_\_\_\_ in Dr. \_\_\_\_\_'s office. Our records indicate that you have an appointment with the doctor. I am sorry, however the doctor will be unable to see you because \_\_\_\_ (give a short reason)\_\_\_\_. I am sorry that I cannot give you more information at this time. If you need emergency care, Dr. \_\_\_\_\_ at \_\_\_\_ (location)\_\_\_\_ has agreed to see patients from this practice. The telephone number there is \_\_\_\_\_. We may soon be contacting you with more information about our situation and instructions about your continuing care.

Thank you for your understanding.

### Sample Letter to Patients About Closing a Practice

Dear [Patient]:

Our records indicate that you are a patient of record at this dental office. Due to \_\_\_\_\_ (give a reason, if possible)\_\_\_\_ this office will be closing on \_\_\_\_ (date)\_\_\_\_. It has been our pleasure to serve your dental needs and we thank you for your patronage. You should begin looking for another dentist. Oftentimes, the recommendation of friends and relatives or contacting the local dental society, are ways of locating another dentist. With your permission, copies of the pertinent information from your record can be made available to a dentist of your choosing. Please do not hesitate to telephone us during normal business hours before the last scheduled day, if you have questions.

After the closing date, all inquiries about the records or other matters should be directed to \_\_\_\_\_ (name of custodian)\_\_\_\_ located at \_\_\_\_\_.

Again, thank you for having been a part of this practice.

Sincerely,

DDS or agent of the dentist

### Sample Letter to Patients about Selling a Practice to Another Dentist

Dear [Patient]:

Our records indicate that you are a patient of record at this dental office. Due to \_\_\_\_\_ (give a reason, if possible) this practice will be closing on \_\_\_\_ (date)\_\_. It has been our pleasure to serve your dental needs and we thank you for your patronage. Dr. \_\_\_\_\_ has purchased my practice. He/she is a \_\_ (year) \_\_ graduate of \_\_\_\_\_. I feel very comfortable about turning my practice over to this well-qualified dentist. Of course, you may desire to have your records sent to another dentist of your choosing. If so, please contact me by letter stating over your signature which dentist should receive a copy of the pertinent information from your record.

If you do not contact us with a request, after the close of the sale, Dr. \_\_\_\_\_ will be the custodian for all of my records and can be reached at \_\_\_\_ (phone number)\_\_. On your next visit he/she may ask you to authorize release of the record to him/her for your continuing care in the office.

Again, I have valued our professional relationship.

Sincerely,

DDS

### Sample Termination of Coverage Letter to Insurance Company

RE: (Policy/certificate) # \_\_\_\_\_

To Whom This May Concern:

Please cancel my coverage under the above policy/certificate effective (date of retirement). Please send a refund of the unearned premium to me at the above address.

Sincerely,

DDS

### Sample Explanation Letter to Insurance Company

To whom this may concern:

I regret to inform you that Dr. \_\_\_\_\_ located at \_\_\_\_\_ died recently. The doctor's NPI # (or T.I.N.) is \_\_\_\_\_.

The undersigned is a volunteer dentist temporarily completing billable services in memory of a deceased colleague. Attached to this letter of explanation is a dental claim form. I will not accept payment for this courtesy. Please mail any payment in the doctor's name to the following address: (indicate an address).

If you have further questions, or need a copy of the official death certificate you may contact (give a name) \_\_\_\_\_ at (address) \_\_\_\_\_ whose relationship to the deceased is that of \_\_\_\_\_.

Thank you,

Name of volunteer:

ID Number:

Dentist License No.:

Mailing Address:

Phone:

## Dentist Out on Illness/Disability

Dear [Patient]:

Dr. [Name] will be out of the office due to [illness/disability] through [datetime frame.] Please be assured that during this time, [his/her] associate, Dr. [Associate's Name], will be available to meet your dental needs during this time. Dr. [Associate's Name] is highly regarded in the dental field and [he/she] has worked with Dr. [Name] for [number] years. Dr. [Name] has the highest greatest confidence in the professional skills of Dr. [Associate's Name].

If you currently have an appointment with Dr. [Name], you will be seen instead by Dr. [Associate's Name]. We think you will like him/her and that you will feel very comfortable and confident in [his/her] care.

If you have any dental problems or would like to schedule a visit, please call our office at [office number].

As always, we are committed to providing you with the best in dental care and patient service, and so we appreciate your understanding. We look forward to Dr. [Name]'s speedy recovery and return to the office.

Sincerely,

Dental Team

## Retirement/Recommended Replacement (1)

Dear [Patient]:

I have received great personal reward from dentistry over the years, but the time has come for me to retire from private practice. Although I won't be seeing you in my office, you and your family will remain in my thoughts. I appreciate the confidence you have placed in me by allowing me to serve your dental needs.

I am recommending that my patients receive their future dental treatment from my replacement, Dr. [Name]. A [year] graduate of [dDental sSchool], Dr. [Name] has been practicing dentistry in [city] for [number] years.

I searched long and hard for a dentist who would provide my patients with excellent clinical treatment and caring, personal service. Dr. [Name] lives up to these high standards.

Dr. [Name] will assume my practice as of [date], and [he/she] is looking forward to meeting you and your family. Your dental records are at my office for use by Dr. [Name] unless you direct us otherwise. If so, we ask that you notify us within 30 days.

Thank you for entrusting us with your dental care needs. I have every confidence that your relationship with Dr. [Name] will be equally successful. Thanks again for making my years of practicing dentistry so memorable and special!

Sincerely,

DDS

## Retirement/Recommended Replacement (2)

Dear [Patient]:

I would like to thank you for your trust and confidence in allowing me to serve as your dentist through the years. It is with mixed emotions that I am announcing my decision to retire and have another dentist acquire my practice. I would like to thank you for your trust and confidence in allowing me to serve as your dentist through the years.

Because I want to be certain that my patients continue to receive the best possible care. Therefore, I have selected Dr. [Name] to carry on my practice. I believe that [he/she] is a competent and caring person who has the qualifications and desire to continue the practice in a highly professional manner.

Dr. [Name] is from [City, State]. [He/sShe] is a [year] graduate of [sSchool] and presently practices dentistry in [City]. [Name] is a member of the [State] Dental Society, [City] District Dental Society, and the American Dental Association.

I will give Dr. [Name] your records, unless you advise us to do otherwise. I feel confident that Dr. [Name] will continue to provide you and your family with the best possible dental care. However, if you choose to seek another dental provider and would like your records transferred, please let us know within 30 days.

Dr. [Name] and the dental team will be contacting you for your next regularly scheduled visit if you are on the active list. If you have not had a recent check-up and we failed somehow to get in touch with you, then please call Dr. [Name] for an appointment. The number here The office number will remain the same, [office number], or [he/she] can be reached at [cell/alternate number].

Thank you again for your loyalty, confidence and friendship!

Sincerely,

DDS

## Retirement from Practice/Replacement

Dear [Patient]:

Because of an increasing commitment of time and travel involved in my position at [place], I no longer feel able to continue to keep my responsibilities to my patients. For these reasons, I am leaving my private practice.

I am happy that the practice has been growing, and grateful that you have helped that growth by referring your friends and relatives to my office. My staff and I truly appreciate your trust in us.

I am recommending that my patients receive future dental treatment from my replacement, Dr. [Name]. I have great confidence in Dr. [Name]'s abilities and I am confident that you will be comfortable and well served. Your dental records will remain at our office for use by Dr. [Name] unless you direct us otherwise. If so, we ask that you notify us within 30 days.

I have enjoyed my practice over the years, and I want to thank you again for your help in making it successful. I also hope that your relationship with Dr. [Name] will be equally successful. Dr. [Name] is looking forward to meeting you and your family, and setting up a regular dental treatment program.

Again, thank you for being our valued patient, and we look forward to seeing you soon!

Sincerely,

DDS

## Practice Closing – No Replacement

Dear [Patient]:

It is with a mixture of sadness and anticipation that I announce the closing of my dental practice upon my retirement in [month/date]. I have practiced dentistry in this community for [number] years, and I have chosen to bring my active practice to a close to spend more time with my family.

I am very fortunate to have practiced dentistry in a community that supports my efforts so greatly. I have enjoyed our friendship and your commitment to oral health over the years. It has been my pleasure to meet the dental needs of you and your family.

If you would like a recommendation for a new dentist, please do not hesitate to contact me at [number]. For questions about how to retrieve your dental records, please call our office at [office number] by [retirement date].

I wish you and your family all the best!

Sincerely,

DDS

## Appendix B

### Suggested Publications from the Council on Dental Practice

1. *Valuing a Practice: A Guide for Dentists*, item #J060; available only through ADA Catalog at 1-800-947-4746. The publication discusses when to do a valuation; legal and tax implications of practice assets; valuation methods; sample contracts and much more.
2. *Transitions Navigating Sales, Associateships & Partnerships in Your Dental Practice*, item #J043; is a comprehensive 116-page book that guides the dentist through practice transitions. Sales, mergers, partnerships, and associateships are covered. Related issues such as financial feasibility, preferred timing, and emotional roadblocks are also addressed. Available through ADA Catalog at 1-800-947-4746 or online at [www.adacatalog.org](http://www.adacatalog.org).
3. *Directory of Dental Practice Appraisers and Brokers*. The *Directory* lists professional dental practice appraisers and valuers and is available at no charge online at <http://www.ada.org/prof/prac/tools/appraisers/search/searchstart.asp>. Includes useful information about background, training or education and services that each offers. A shipping and handling fee applies for printed copies; call the ADA toll free number, extension 2895.
4. *Directory of Dental Practice Management Consultants*. Contains information about how to select a dental practice management consultant and is available online at <http://www.ada.org/prof/prac/tools/practice/search/searchstart.asp>. A shipping and handling fee will apply for printed copies; call the ADA toll free number, extension 2895.
5. *Guidelines for the Development of Mutual Aid Agreements in Dentistry*, gives useful information about how a small group of dentists can formally agree to temporarily cover each other's practice in the event that a participant to the agreement is stricken with long-term illness or dies. The *Guidelines* are and is available online at [http://www.ada.org/prof/resources/topics/dentalpractice\\_mutualaid.pdf](http://www.ada.org/prof/resources/topics/dentalpractice_mutualaid.pdf). A shipping and handling fee will apply for printed copies; call the ADA toll free number, extension 2895. .
6. *General Guidelines for Referring Dental Patients*, revised June 2007, available at [http://www.ada.org/prof/resources/topics/referring\\_guidelines.pdf](http://www.ada.org/prof/resources/topics/referring_guidelines.pdf).
7. *Dentist Well-Being Directory*. To obtain dentist wellness assistance information from the American Dental Association, telephone ADA's telephone toll-free number ext. 2622 or 1-312-440-2622 or view it online <http://www.ada.org/prof/prac/wellness/substance.asp>.
8. *Dental Records* provides helpful information for dentists and the dental team about the dental record, including the components of a dental record, ownership of the record, how to make entries, how to transfer records, how long records should be kept and disposal information. Available as a free online resource is the Dental Records (<http://www.ada.org/prof/resources/topics/dentalpractice.asp>), with a detailed table of contents to help users quickly locate
9. For dental practice management information write, fax, e-mail or telephone the Council on Dental Practice.

Council on Dental Practice  
211 East Chicago Avenue  
Chicago, IL 60611-2678  
Fax 1-312-440-2924  
Telephone 1-312-440-2895  
E-mail: [dentalpractice@ada.org](mailto:dentalpractice@ada.org)

## Appendix C

### Suggested Closing Checklist: Retirement

(\*Timelines will vary according to state law requirements. Make sure to seek appropriate professional advice for the then-current requirements of your jurisdiction)

(Table 1)

90 Days	<ul style="list-style-type: none"><li>• Contact personal attorney and accountant</li><li>• Set closing date and notify staff</li><li>• Inventory supplies and adjust future orders</li><li>• Appraise and decide fate of dental equipment</li></ul>
60 days	<ul style="list-style-type: none"><li>• Send closing announcement letter to patients</li><li>• Begin incentives in order to retain staff</li><li>• Restrict new non-emergency cases to those that can routinely be completed before the closing date or that could be done in phases</li></ul>
30 Days	<ul style="list-style-type: none"><li>• Telephone DEA, Board of Dentistry, State &amp; Nat'l Dental Association to report planned office closing</li><li>• Sort patient records into active, inactive and minors. Discard or store records appropriately.</li><li>• Notify utilities</li></ul>

## Closing Checklist: Dentist's Long-Term Illness or Death (Table 2)

First Day	<ul style="list-style-type: none"><li>• Assemble staff and relay what is known</li><li>• Clarify what will be said to patients about the dentist's condition or situation</li><li>• Cancel appointments for the day</li></ul>
First Week	<ul style="list-style-type: none"><li>• Hold a staff meeting and make work assignments that ease the panic</li><li>• Send non-essential staff home until needed</li><li>• Control access to the office and to records</li><li>• Telephone attorney and accountant. Consider hiring a practice broker.</li><li>• Arrange for colleagues to see emergency patients or for a temporary dentist to cover the practice until owner's recovery or until sale (Be sure to obtain a covenant not to compete to prevent patients continuing care in the office of the temporary dentist.)</li><li>• Prepare a unified message for patients and others</li></ul>
First Month	<ul style="list-style-type: none"><li>• Duplicate records for other dentists upon written request from patients</li><li>• Evaluate staffing requirement</li><li>• Monitor accounts receivable</li><li>• Have the practice valued for a possible sale</li><li>• Obtain a real estate appraisal</li><li>• Develop &amp; implement comprehensive marketing plan to obtain bids if the practice is to be sold.</li><li>• Begin showing the practice, if for sale. Don't discontinue marketing effort with first offer.</li></ul>
Last Month	<ul style="list-style-type: none"><li>• Sort patient records into active, inactive and minors. Discard or store records appropriately</li><li>• Inform landlord about potential vacancy or sale</li><li>• Announce who to contact for information about dental patient records that will be stored</li><li>• Decide the fate of equipment</li><li>• Offer incentives to keep staff</li></ul>
Last Week	<ul style="list-style-type: none"><li>• Disinfect countertops, equipment and instruments prior to removal</li><li>• Properly dispose of chemicals</li></ul>

## Appendix D

### Tips at Retirement for Getting Top Dollar for Your Practice

1. Hire and keep ambitious associates by treating them fairly and compensating them well. Today's dental associate(s) could be tomorrow's practice purchaser. After all, who other than yourself and the associate(s) knows more about the practice or wants more to secure its future? To learn more about this business arrangement, see the ADA publication *Associateships: A Guide for Owners and Prospective Associates* (J045, telephone ADA Catalog at 1-800-947-4746 or [www.adacatalog.org](http://www.adacatalog.org)).
2. Plan to sell and retire from the practice while practice growth and earnings are high. This generally means sooner rather than later; and younger rather than older.
3. In the years leading up to retirement and sale of the practice, keep a good patient mix with higher incomes. Don't let your typical patient's profile grow old with the practice. Aim for twenty new patients each month. Take continuing education courses throughout your dental career and keep up with new technology and techniques.
4. Excellent personal contacts and visibility within the community and profession can help to ensure a good image that later could translate into higher goodwill at a sale.
5. Strive to keep costs down. This will distinguish your practice and boost the bottom line while increasing its attractiveness to potential buyers.
6. Keep excellent patient records. They are among the first items that a potential buyer will review.
7. Gather information for potential buyers about the community, including population data, demographic trends and economic factors. You should be prepared, for example, to tell a potential buyer factual financial information about your town's leading employer. A public library, Chamber of Commerce or the U. S. Census Bureau (<http://www.census.gov/>) may be able help you obtain information about your town.
8. Know how your practice differs in the competitive environment of your community. List what is special about your practice and patients.
9. If you have had a long-term relationship with a bank, find out if it is willing to provide financing for a buyer for your practice.
10. An updated appearance is important, however, sometimes too much emphasis is placed on the importance of new equipment. Be prepared to demonstrate that your equipment is in good working order. Show receipts that document the repair history of key equipment or components and warranty the equipment.
11. The practice should appear clean and orderly. Prior to a sale consider painting, changing the wallpaper or light fixtures, etc., but don't overspend. You may not be able to recover excessive refurbishing costs.
12. Consider introducing a serious buyer to the staff, if appropriate.
13. State your willingness to write a letter of introduction to patients and/or a newspaper article that endorses the new owner. Indicate your willingness to host a party that includes all of the patients to announce your retirement and introduces the new practice owner.
14. A protracted negotiation that fails could hamper getting a good or better deal with another buyer later if your staff or patients leave out of insecurity.
15. Obtain the services of an experienced dental practice broker. This individual will screen potential buyers, place advertisements and represent your interests during negotiations.

16. To market your practice, professional societies, dental schools nearby, dental residency programs and dental suppliers can be good resources. However, blanketing your community with news of your practice's potential sale or closure could backfire with early patient losses and reduced income long before a buyer is found.
17. Consider offering a long term buy-in strategy of up to ten years prior to retirement and later staying on as an associate for a short time.

## Appendix E

### List of Constituent Dental Societies

#### Alabama Dental Association

836 Washington Ave.  
Montgomery, AL 36104  
Phone: 334.265.1684  
FAX: 334.262.6218  
E-mail: [contactus@aldaonline.org](mailto:contactus@aldaonline.org)  
Web: [www.aldaonline.org](http://www.aldaonline.org)

#### Alaska Dental Society

9170 Jewel Lake Rd. #203  
Anchorage, AK 99502  
Phone: 907.563.3003  
FAX: 907.563.3009  
E-mail: [akdental@alaska.net](mailto:akdental@alaska.net)  
Web: [www.akdental.org](http://www.akdental.org)

#### Arizona Dental Association

3193 N. Drinkwater Blvd  
Scottsdale, AZ 85251  
Phone: 480.344.5777  
FAX: 480.344.1442  
E-mail: [rick@azda.org](mailto:rick@azda.org)  
Web: [www.azda.org](http://www.azda.org)

#### Arkansas State Dental Association

2501 Crestwood, Suite 205  
N. Little Rock, AR 72116  
Phone: 501.834.7650  
FAX: 501.771.1016  
E-mail: [asda@aristotle.net](mailto:asda@aristotle.net)  
Web: [www.dental-asda.org](http://www.dental-asda.org)

#### California Dental Association

1201 K Street  
Sacramento, CA 95814  
Phone: 916.443.0505  
(in CA) 800.232.7645  
FAX: 916.443.2943  
E-mail: [info@cda.org](mailto:info@cda.org)  
Web: [www.cda.org](http://www.cda.org)

#### Colorado Dental Association

3690 S. Yosemite, Ste 100  
Denver, CO 80237-1808  
Phone: 303.740.6900  
FAX: 303.740.7989  
E-mail: [info@cdaonline.org](mailto:info@cdaonline.org)  
Web: [www.cdaonline.org](http://www.cdaonline.org)

#### Connecticut State Dental Association

835 W. Queen St.  
Southington, CT 06489  
Phone: 860.378.1800  
FAX: 860.378.1807  
E-mail: [noel@cstda.com](mailto:noel@cstda.com)  
Web: [www.cstda.com](http://www.cstda.com)

#### Delaware State Dental Society

The Christiana Executive Campus  
200 Continental Dr., Suite 111  
Newark, DE 19713  
Phone: 302.368.7634  
FAX: 302.368.7669  
E-mail: [dsds@dol.net](mailto:dsds@dol.net)  
Web: [www.dedental.com](http://www.dedental.com)

#### Dist. of Columbia Dental Society

502 C. St. NE  
Washington, DC 20002  
Phone: 202.547.7613  
FAX: 210.546.1482  
E-mail: [info@dcdental.org](mailto:info@dcdental.org)  
Web: [www.dcdental.org](http://www.dcdental.org)

#### Florida Dental Association

1111 E. Tennessee St., Ste 102  
Tallahassee, FL 32308-6913  
Phone: 850.681.3629  
FAX: 850.561.0504  
E-mail: [fda@floridadental.org](mailto:fda@floridadental.org)  
Web: [www.floridadental.org](http://www.floridadental.org)

#### Georgia Dental Association

7000 Peachtree.Dunwoody Rd.  
Ste. 200, Bldg. 17  
Atlanta, GA 30328-1655  
Phone: 404.636.7553  
FAX: 404.633.3943  
E-mail: [phillips@gadental.org](mailto:phillips@gadental.org)  
Web: [www.gadental.org](http://www.gadental.org)

#### Hawaii Dental Association

1345 S Beretania St.  
Honolulu, HI 96814  
Phone: 808.593.7956  
FAX: 808.593.7636  
E-mail: [hda@hawaiidentalassociation.net](mailto:hda@hawaiidentalassociation.net)  
Web: [www.hawaiidentalassociation.net](http://www.hawaiidentalassociation.net)

#### Idaho State Dental Association

1220 W. Hays St.  
Boise, ID 83702-5315  
Phone: 208.343.7543  
FAX: 208.343.0775  
E-mail: [info@isdaweb.com](mailto:info@isdaweb.com)  
Web: [www.isdaweb.com](http://www.isdaweb.com)

**Illinois State Dental Society**

1010 S. 2nd St.  
P.O. Box 376  
Springfield, IL 62704  
Phone: 217.525.1406  
FAX; 217.525.8872  
E-mail: [rechner@isds.org](mailto:rechner@isds.org)  
Web: [www.isds.org](http://www.isds.org)

**Indiana Dental Association**

P.O. Box 2467  
401 W. Michigan Street  
Indianapolis, IN 46206-2467  
Phone: 800.562.5646  
Or 316.634.2610  
E-mail: [dbush@indental.org](mailto:dbush@indental.org)  
Web: [www.indental.org](http://www.indental.org)

**Iowa Dental Association**

5530 West Parkway, Ste. 100  
Johnson, IA 50131  
Phone: 515.986.5605  
FAX: 515.986.5626  
E-mail: [info@iowadental.org](mailto:info@iowadental.org)  
Web: [www.iowadental.org](http://www.iowadental.org)

**Kansas Dental Association**

5200 SW Huntoon St.  
Topeka, KS 66604-2398  
Phone: 913.272.7360  
FAX: 913.272.2301  
E-mail: [kevin@ksdental.org](mailto:kevin@ksdental.org)  
Web: [www.ksdental.org](http://www.ksdental.org)

**Kentucky Dental Association**

1940 Princeton Dr.  
Louisville, KY 40205-1873  
Phone : 502.459.5373  
FAX: 502.458.5915  
E-mail: [mike@kyda.org](mailto:mike@kyda.org)  
Web: [www.kyda.org](http://www.kyda.org)

**Louisiana Dental Association**

7833 Office Park Blvd.  
P O Box 261173  
Baton Rouge, LA 70809  
Phone: 225.926.1986  
FAX: 225.926.1886  
E-mail: [info@ladental.org](mailto:info@ladental.org)  
Web: [www.ladental.org](http://www.ladental.org)

**Maine Dental Association**

P.O.Box 215  
Manchester, ME 04351  
Phone: 207.622.7900  
FAX: 207.622.6210  
E-mail: [info@medental.org](mailto:info@medental.org)  
Web: [www.medental.org](http://www.medental.org)

**Maryland State Dental Association**

6410F Dobbin Road  
Columbia, MD 21045  
Phone: 410.964.2880  
FAX; 410-964.0583  
E-mail: [mddent@msda.com](mailto:mddent@msda.com)  
Web: [www.msda.com](http://www.msda.com)

**Massachusetts Dental Society**

Two Willow St. #200  
Southborough, MA 01754  
Phone: 508.480.9797  
FAX: 508.480.0002  
E-mail; [madental@massdental.org](mailto:madental@massdental.org)  
Web: [www.massdental.org](http://www.massdental.org)

**Michigan Dental Association**

230 Washington Sq. N., Ste. 208  
Lansing, MI 48933-1312  
Phone: 517.372.9070  
FAX: 517.372.0008  
E-mail : [mda@michigandental.org](mailto:mda@michigandental.org)  
Web : [www.michigandental.org](http://www.michigandental.org)

**Minnesota Dental Association**

2236 Marshall Ave.  
Saint Paul, MN 55104  
Phone: 651.646.7454  
FAX: 651.646.8246  
E-mail: [info@mndental.org](mailto:info@mndental.org)  
Web: [www.mndental.org](http://www.mndental.org)

**Mississippi Dental Association**

2630 Ridgewood Rd., Ste. C  
Jackson, MS 39216-4903  
Phone: 601.982.0442  
FAX: 601.366.3050  
E-mail: [connie@msdental.org](mailto:connie@msdental.org)  
Web: [www.msdental.org/cms](http://www.msdental.org/cms)

**Missouri Dental Association**

3340 American Ave.  
Jefferson City, MO 65109  
Phone: 573.634.3436  
FAX: 573.635.0764  
E-mail: [jake@msdental.org](mailto:jake@msdental.org)  
Web: [www.modental.org](http://www.modental.org)

**Montana Dental Association**

17½ S. Last Chance Gulch  
Helena, MT 59624  
Phone: 406.443.2061  
FAX: 406.443.1546  
E-mail: [mda@mt.net](mailto:mda@mt.net)  
Web: [www.mtdental.com](http://www.mtdental.com)

**Nebraska Dental Association**

3120 "O" St.  
Lincoln, NE 68510-1533  
Phone: 402.476.1704  
Fax: 402.476.2641  
E-mail: [info@nedental.org](mailto:info@nedental.org)  
Web: [www.nedental.org](http://www.nedental.org)

**Nevada Dental Association**

8863 W. Flamingo Rd., Ste. 102  
Las Vegas, NV 89147  
Phone: 702.255.4211  
FAX: 702.255.3302  
E-mail: [nda@lasvegas.net](mailto:nda@lasvegas.net)  
Web: [www.nvda.org](http://www.nvda.org)

**New Hampshire Dental Society**

23 South State St.  
Concord, NH 03301-2229  
Phone: 603.225.5961  
FAX: 603.226.4880  
E-mail: [nhds@nhds.org](mailto:nhds@nhds.org)  
Web: [www.nhdental.com](http://www.nhdental.com)

**New Jersey Dental Association**

One Dental Plaza  
P.O. Box 6020  
North Brunswick, NJ 08902-6020  
Phone: 732.821.9400  
FAX: 732.821.1082  
E-mail: [ameisel@njda.org](mailto:ameisel@njda.org)  
Web: [www.njda.org](http://www.njda.org)

**New Mexico Dental Association**

9201 Montgomery Blvd. NE, Ste. 601  
Albuquerque, NM 87111  
Phone: 505.294.1368  
FAX: 505.294.9958  
E-mail: [kcravens@nmdental.org](mailto:kcravens@nmdental.org)  
Web: [www.newmexicodental.org](http://www.newmexicodental.org)

**New York State Dental Association**

20 Corporate Woods Blvd., Ste. 602  
Albany, NY 12211  
Phone: 518.465.0044  
FAX: 518.465.3219  
E-mail: [info@nysdental.org](mailto:info@nysdental.org)  
Web: [www.nysdental.org](http://www.nysdental.org)

**North Carolina Dental Society**

P.O. Box 4099  
Cary, NC 27519  
Phone: 919.677.1396  
FAX: 919.677.1397  
E-mail: [info@ncdental.org](mailto:info@ncdental.org)  
Web: [www.ncdental.org](http://www.ncdental.org)

**North Dakota Dental Association**

P115 N. 4<sup>th</sup> Street  
Bismarck, ND 58501-1332  
Phone: 701.223.8870  
FAX: 701.223.0855  
E-mail: [ndda@midconetwork.com](mailto:ndda@midconetwork.com)  
Web: [www.ndental.com](http://www.ndental.com)

**Ohio Dental Association**

1370 Dublin Rd.  
Columbus, OH 43215-1009  
Phone: 614.486.2700  
FAX: 614.486.0381  
E-mail: [dentist@oda.org](mailto:dentist@oda.org)  
Web: [www.oda.org](http://www.oda.org)

**Oklahoma Dental Association**

317 NE 13th St.  
Oklahoma City, OK 73104  
Phone: 405.848.8873 or 800.876.8890  
Fax: 405.848.8875  
E-mail: [information@okda.org](mailto:information@okda.org)  
Web: [www.okda.org](http://www.okda.org)

**Oregon Dental Association**

8699 S.W. Sun Place  
P.O. Box 3710  
Wilsonville, OR 97070-3710  
Phone: 503.218.2010 or 800.452.5628  
FAX: 503.218.2009  
E-mail: [info@oregondental.org](mailto:info@oregondental.org)  
Web: [www.oregondental.org](http://www.oregondental.org)

**Pennsylvania Dental Association**

3501 North Front St  
Harrisburg, PA 17105-3341  
Phone: 717.234.5941  
FAX: 717.234.2186  
E-mail: [ckc@padental.org](mailto:ckc@padental.org)  
Web: [www.padental.org](http://www.padental.org)

**Colegio de Cirujanos Dentistas  
de Puerto Rico**

Avenida Domenech #200  
Hato Rey, PR 00918  
Phone: 787.764.1969  
FAX: 787.763.6335  
Email: [administratdor@ccdpr.org](mailto:administratdor@ccdpr.org)  
Web: [www.ccdpr.org](http://www.ccdpr.org)

**Rhode Island Dental Association**

200 Centerville Rd., Ste 7  
Warwick, RI 02886-0204  
Phone: 401.732.6833  
FAX: 401.732.9351  
E-mail: [info@ridental.com](mailto:info@ridental.com)  
Web: [www.ridental.com](http://www.ridental.com)

**South Carolina Dental Association**

120 Stonemark Ln.  
Columbia, SC 29210-3841  
Phone: 800.327.2598  
or 803.750.2277  
FAX: 803.750.1644  
E-mail: [lathamp@scda.org](mailto:lathamp@scda.org)  
Web: [www.scda.org](http://www.scda.org)

**South Dakota (CRDTS)**

P.O. Box 1194  
804 N. Euclid Ave., Suite 103  
Pierre, SD 57501-1194  
Phone: 605.224.9133  
Fax: 605.224.9168  
E-mail: [info@sddental.org](mailto:info@sddental.org)  
Web: [www.sddental.org](http://www.sddental.org)

**Tennessee Dental Association**

660 Bakers Bridge Ave.  
Suite 300  
Franklin, TN 37067  
Phone: 615.628.0208  
FAX: 615.628.0214  
E-mail: [tda@tenndental.org](mailto:tda@tenndental.org)  
Web: [www.tenndental.org](http://www.tenndental.org)

**Texas Dental Association**

1946 South IH.35, Suite 400  
Austin, TX 78704  
Phone: 512.443.3675  
FAX: 512.443.3031  
E-mail: [stefanie@tda.org](mailto:stefanie@tda.org)  
Web: [www.tda.org](http://www.tda.org)

**Utah Dental Association**

1151 E. 3900 S., Ste. 160  
Salt Lake City, UT 84124  
Phone: 801.261.5315  
FAX: 801.261.1235  
E-mail: [uda@uda.org](mailto:uda@uda.org)  
Web: [www.uda.org](http://www.uda.org)

**Vermont State Dental Society**

100 Dorset St., Ste. 18  
South Burlington, VT 05403  
Phone: 802.864.0115  
FAX: 802.864.0116  
E-mail: [info@vsda.org](mailto:info@vsda.org)  
Web: [www.vsds.org](http://www.vsds.org)

**Virgin Islands Dental Association**

Med Arts Complex – Suite 10  
St. Thomas, VI 00810  
Phone: 340.777.5950  
FAX: 340.775.4172  
Email: [jawdocvi@netwcape.net](mailto:jawdocvi@netwcape.net)  
Web:

**Virginia Dental Association**

7525 Staples Mill Road  
Richmond, VA 23228  
Phone: 804.261.1610  
FAX: 804.261.1660  
E-mail: [Dickinson@vadental.org](mailto:Dickinson@vadental.org)  
Web: [www.vadental.org](http://www.vadental.org)

**Washington State Dental Association**

1001 Fourth Ave., Suite 3800  
Seattle, WA 98154  
Phone: 206.448.1914  
FAX: 206.443.9266  
E-mail: [info@wsda.org](mailto:info@wsda.org)  
Web: [www.wsda.org](http://www.wsda.org)

**West Virginia Dental Association**

2016 ½ Kanawha Blvd. E.  
Charleston, WV, 25311-2204  
Phone: 304.344.5246  
FAX: 304.344.5316  
E-mail: [info@wvdental.org](mailto:info@wvdental.org)  
Web: [www.wvdental.org](http://www.wvdental.org)

**Wisconsin Dental Association**

6737 W. Washington St.  
Suite 2360  
West Allis, WI 53214  
Phone: 800.364.7646 or 414.276.4520  
FAX: 414.276.8431  
E-mail: [mpaget@wda.org](mailto:mpaget@wda.org)  
Web: [www.wda.org](http://www.wda.org)

**Wyoming Dental Association**

1637 S Spruce St.  
Casper, WY 82601-4155  
Phone: 307.237.1186  
FAX: 307.237.1187  
E-mail: [wyodental@msn.com](mailto:wyodental@msn.com)  
Web: [www.wyda.org](http://www.wyda.org)

## Appendix F Useful Information and Documents Needed at the Time of a Sale

The following list of documents may be helpful when buying or selling a dental practice. You may also want to consult with your attorney or accountant about additional items that may be particular to your transaction.

Dental Equipment
Description
Year of manufacture
Brand name
Model number or type
Serial number
Capabilities/capacity
Repair history/maintenance record
Warranty
Owner's manual
Inspection record (license/permit)

Business Office Equipment
Computer/printer/copier
Service/Support contact
Brand name
Model/serial number
Capabilities/capacity
Repair history/maintenance record
Warranty/date purchased
Owner's manual
Software version

Practice Numbers You Should Know (per year for last three years)
Number of active patients <sup>xi</sup>
Dentist & hygiene production
Account receivable
Number of new patients per month (and referral source)
Capabilities/capacity
Production per patient
Production per hour
Case acceptance rate
Collection rate
Fee-for-service/managed care ratio
Total number of hours worked per month
Dentist
Hygienist

<b>Valuation Documents</b>
Appraiser's contact information
Date and purpose of valuation
Valuation methodology and determination
Other Documents:
<ul style="list-style-type: none"> <li>• Mortgage or copy of lease agreement</li> </ul>
<ul style="list-style-type: none"> <li>• Copy of sales agreement or contract including warranties &amp; non-compete covenants</li> </ul>
<ul style="list-style-type: none"> <li>• Covenant (either the seller; or a temporary dentist hired/voluntary during a crisis)</li> </ul>
<ul style="list-style-type: none"> <li>• Mutual aid agreement</li> </ul>
<ul style="list-style-type: none"> <li>• Capitation plan, preferred provider organization (PPO) agreement, or dental management services organization agreement</li> </ul>
<ul style="list-style-type: none"> <li>• Federal tax return (last 3 yrs, 1040 &amp; 1120)</li> </ul>
<ul style="list-style-type: none"> <li>• Balance sheet</li> </ul>
<ul style="list-style-type: none"> <li>• Accounts receivable aging information</li> </ul>
<ul style="list-style-type: none"> <li>• Fee schedule</li> </ul>
<ul style="list-style-type: none"> <li>• Any outstanding legal judgments or claims</li> </ul>
Policy & Personnel Records
<ul style="list-style-type: none"> <li>• Employee office manual</li> </ul>
<ul style="list-style-type: none"> <li>• Fee Schedule</li> </ul>
<ul style="list-style-type: none"> <li>• Staff <ul style="list-style-type: none"> <li>Job descriptions, responsibilities, payroll records, time sheets, injury and safety records, worker's compensation records, health/insurance participation, retirement plan, medical savings account, salary information, resume, certification or license, affiliations, continuing education &amp; training, documentation of malpractice coverage.</li> </ul> </li> </ul>

<b>OSHA &amp; Other Federal Compliance</b>
Hazard communication program
List of hazardous chemicals
Material safety data sheets (MSDS)
Emergency action/fire prevention plans (eleven or more employees)
OSHA injury log (OSHA Form 101 or an equivalent and Form 200 from previous 5 years)
Medical records for employees having occupational exposure
HIPAA privacy/security policies & procedures
Exposure control plan
Partnership agreement
Dental laboratories
Major dental equipment supplier
Original architect/contractor-builder
Anesthetic gas supplier
Badge monitoring service (nitrous oxide or x-ray)
Waste hauler for garbage and/or hazardous wastes
Managed care plans/agreements

Suggested Documents/Information Supplied by the Buyer
Personal documentation, such as:
Copy of dental license
Federal tax returns (last 3 years)
Line of credit
Business/Marketing Plan
Copy of purchase/sales agreement
Cash flow projection
Strategic plan
Agreements
Agreement to employ seller (optional)
Non-compete agreement (from seller)

## Appendix G Advisory Team Contact Information

Accountant				
Company Name:			Contact:	
Office Address:				
City:		State	Zip	
Telephone:	Fax	E-mail		
Web site:	Contract?	Yes	No	

Practice Management Consultant				
Company Name:			Contact:	
Office Address:				
City:		State	Zip	
Telephone:	Fax	E-mail		
Web site:	Contract?	Yes	No	

Practice Broker				
Company Name:			Contact:	
Office Address:				
City:		State	Zip	
Telephone:	Fax	E-mail		
Web site:	Contract?	Yes	No	

Practice Appraiser				
Company Name:			Contact:	
Office Address:				
City:		State	Zip	
Telephone:	Fax	E-mail		
Web site:	Contract?	Yes	No	

Landlord/Lease holder				
Company Name:			Contact:	
Office Address:				
City:		State	Zip	
Telephone:	Fax	E-mail		
Web site:	Contract?	Yes	No	

Risk Management insurance Carrier				
Company Name:			Contact:	
Office Address:				
City:		State	Zip	
Telephone:	Fax	E-mail		
Web site:	Contract?	Yes	No	

Patient Insurance Carrier (PPO, HMO or other)				
Company Name:			Contact:	
Office Address:				
City:		State	Zip	
Telephone:	Fax	E-mail		
Web site:	Contract?	Yes	No	

Practice Healthcare Insurance Carrier (PPO, HMO or other)					
Company Name:			Contact:		
Office Address:					
City:		State		Zip	
Telephone:		Fax		E-mail	
Web site:			Contract?	Yes	No

Credit card Company					
Company Name:			Contact:		
Office Address:					
City:		State		Zip	
Telephone:		Fax		E-mail	
Web site:			Contract?	Yes	No

Practice Bank or Financial Institution					
Company Name:			Contact:		
Office Address:					
City:		State		Zip	
Telephone:		Fax		E-mail	
Web site:			Contract?	Yes	No

Practice Software Company					
Company Name:			Contact:		
Office Address:					
City:		State		Zip	
Telephone:		Fax		E-mail	
Web site:			Contract?	Yes	No

Web Site Design Company					
Company Name:			Contact:		
Office Address:					
City:		State		Zip	
Telephone:		Fax		E-mail	
Web site:			Contract?	Yes	No

Other					
Company Name:			Contact:		
Office Address:					
City:		State		Zip	
Telephone:		Fax		E-mail	
Web site:			Contract?	Yes	No

Other					
Company Name:			Contact:		
Office Address:					
City:		State		Zip	
Telephone:		Fax		E-mail	
Web site:			Contract?	Yes	No

**Dentists in Mutual Aid group (*Locum Tenens*)**

<b>Dentists in Mutual Aid group (<i>Locum Tenens</i>)</b>		
<b>Dentist:</b>		
<b>Office Address:</b>		
<b>City:</b>	<b>State</b>	<b>Zip</b>
<b>Office Telephone:</b>	<b>Fax</b>	
<b>Home/Mobile phone</b>	<b>E-mail</b>	
<b>Dentist:</b>		
<b>Office Address:</b>		
<b>City:</b>	<b>State</b>	<b>Zip</b>
<b>Office Telephone:</b>	<b>Fax</b>	
<b>Home/Mobile phone</b>	<b>E-mail</b>	
<b>Dentist:</b>		
<b>Office Address:</b>		
<b>City:</b>	<b>State</b>	<b>Zip</b>
<b>Office Telephone:</b>	<b>Fax</b>	
<b>Home/Mobile phone</b>	<b>E-mail</b>	
<b>Dentist:</b>		
<b>Office Address:</b>		
<b>City:</b>	<b>State</b>	<b>Zip</b>
<b>Office Telephone:</b>	<b>Fax</b>	
<b>Home/Mobile phone</b>	<b>E-mail</b>	
<b>Dentist:</b>		
<b>Office Address:</b>		
<b>City:</b>	<b>State</b>	<b>Zip</b>
<b>Office Telephone:</b>	<b>Fax</b>	
<b>Home/Mobile phone</b>	<b>E-mail</b>	

## Appendix H Web Sites

### Tips for Evaluating Information on the Internet

The Internet touches every aspect of our lives, whether we use it to keep in touch with friends and family, research a question, shop for a gift or just read the news. But with all of the available information, how do we know what is trustworthy? To help evaluate and recognize Web sites that are providing credible information, consider the following tips:

- Is it clear who is responsible for the contents of the page?
- Is there a link to a page describing the purpose of the sponsoring organization?
- Is there a way of verifying the legitimacy of the page's sponsor such as a telephone number or postal address to contact for more information?
- Are informational sources clearly available for verification by another source?
- Is it clear who wrote the material and are the author's qualifications clearly stated?
- Is the information presented as an opinion and clearly stated as such? Is the source a qualified professional or organization?
- Can you easily determine when the site was last updated to determine if the information is current?
- Does the information contain several grammatical, spelling and typographical errors? Such errors indicate a lack of quality control and can actually produce inaccuracies in information.
- Does the site have a privacy policy? If not, the site should not ask for personal information.
- If a copyright protects the material, who holds it?

If the Web site or the information contained within the Web site is not consistent with these guidelines, make sure you check another source to ensure you are getting the most accurate information available.<sup>xii</sup>

#### **Alzheimer's Association**

<http://www.alz.org/>

#### **AARP Bereavement Outreach Program**

One-on-one peer counseling using recently bereaved, trained volunteers [http://www.aarp.org/families/grief\\_loss/](http://www.aarp.org/families/grief_loss/)

#### **Alliance of the ADA**

Surviving Spouse Package  
1-800-621-8099 ext. 2865  
<http://www.allianceada.org/>

**American Academy of Family Physicians**

Information on Do Not Resuscitate (DNR) and Advance Directives  
<http://familydoctor.org/003.xml>

**American Bar Association Pro Bono Directory**

<http://www.abanet.org/legalservices/probono/directory.html#>

**American Cancer Society**

Cancer information and referrals  
<http://www.cancer.org>

**American Dental Association, Health & Wellness**

<http://www.ada.org/prof/prac/wellness/program.asp>

**American Dental Association, Disability**

<http://www.ada.org/prof/prac/wellness/disability.asp>

**American Hospice Foundation**

<http://www.americanhospice.org/>

**Business Resources for Disabled People**

<http://www.disabilityinfo.gov/digov-public/public/DisplayPage.do?parentFolderId=500>

**[Disabilityinfo.gov](http://www.disabilityinfo.gov)****Healthfinder**

<http://www.healthfinder.gov/>

**Independent Living Centers for the Disabled**

<http://www.jik.com/ilcs.html>

**Mayo Health**

Mayo Clinic  
<http://www.mayohealth.org/>

**Medline Plus**

Free access to National Library of Medicine's database  
<http://medlineplus.gov/>

**Material Safety Data Sheets**

*Compiled by the ADA Division of Science*

- Laboratory Safety Institute –  
MSDSs and other chemical information sources <http://www.labsafety.org/cheminfo/links.htm>  
This is a large index with links to ATSDR Toxfaqs, NIOSH Safety Cards, and a number of MSDS sites.
- Oklahoma State University, Online Safety Library–  
Material Safety Data Sheets  
<http://www.pp.okstate.edu/ehs/links/msds.htm>  
Has links to MSDS sites and other chemical databases, plus an excellent section with safety training handouts.
- University of California, San Diego–  
Material Safety Data Sheets (MSDS)  
<http://blink.ucsd.edu/Blink/External/Topics/Policy/0,1162,4304,FF.html>  
An index with links to MSDS and chemical fact sheets.

**National Association for Information Destruction, Inc.**

<http://www.naidonline.org/members.html>

**National Cancer Institute**

<http://www.nih.nci.gov>

**National Institutes of Health**

<http://www.nih.gov/>

**Partnership for Caring**

Website contains free Living Will & Medical Power of Attorney Documents

<http://www.partnershipforcaring.org/HomePage/>

**PubMed**

<http://www.ncbi.nlm.nih.gov/sites/entrez>

**Rehabilitation Institute of Chicago**

Amputee, Stroke, MS, and Spinal Cord injury support groups; legal clinic referral, health resource center for disabled women

<http://www.ric.org/>

**Social Security Administration**

<http://www.ssa.gov/>

**Social Security Disability Benefits**

<http://www.ssa.gov/dibplan/dqualify.htm>

**Veteran's Memorial Benefits**

<http://www.cem.va.gov/>

**WebMD**

<http://www.webmd.com/>

## Endnotes

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- <sup>vii</sup> Proper Disposal of Prescription Drugs, [www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov), accessed Sept. 10, 2008.
- <sup>viii</sup> Practitioner’s Manual, An Informational Outline of the Controlled Substance Act, United States Department of Justice, Drug Enforcement Administration, Office of Diversion Control, 2006 Edition.
- <sup>ix</sup> Wikipedia, <http://en.wikipedia.org/wiki/Hospice#Concept>, accessed August 26, 2008.
- <sup>x</sup> Wikipedia, [http://en.wikipedia.org/wiki/Durable\\_power\\_of\\_attorney](http://en.wikipedia.org/wiki/Durable_power_of_attorney), accessed August 26, 2008.
- <sup>xi</sup> ADA Policy, (Trans. 1991:621); As defined by policy of the American Dental Association, (Trans. 1991:621), an active dental patient of record is any individual in either of the following two categories: Category I - patients of record who have had dental service(s) provided by the dentist in the past twelve (12) months; Category II patients of record who have had dental service(s) provided by the dentist in the past twenty four (24) months, but not within the past twelve (12) months. An inactive patient is any individual who has become a patient of record and has not received any dental services(s) by the dentists in the past twenty four (24) months.

The above definition is typically used in practice appraisals and may not be the same definition of an active patient used in a dental office in records maintenance.

- <sup>xii</sup> American Dental Association, “Tips For Evaluating Information On The Internet,” <http://www.ada.org/public/media/presskits/fillings/tips.pdf>, accessed August 29, 2008.

# Dental Records



American Dental Association  
[www.ada.org](http://www.ada.org)

*Council on Dental Practice  
Division of Legal Affairs*

*Seven out of ten dentists are members of the ADA.*

2007

# Dental Records

## Acknowledgments

This publication was developed by the Council on Dental Practice and the Division of Legal Affairs.

The Mission of the Council on Dental Practice is to recommend policies and provide resources to empower our members to continue development of the dental practice, and to enhance their personal and professional lives for the betterment of the dental team and the patients they serve.

## Disclaimer

This ADA publication is designed especially for dentists and the dental team to provide helpful information about the dental record. This publication is not intended or offered as legal or other professional advice. Laws vary from state to state and thus, readers should consult with their personal legal counsel and malpractice insurer to access the applicable laws in their state. *Dental Records* is based in part on questions frequently asked by our members. It is our hope that dentists and their team members will find this publication, helpful but in no way a substitute for actual legal advice given by an attorney in your state.

# Dental Records

## Introduction

The dental record, also referred to as the patient's chart, is the official office document that records all of the treatment done and all patient-related communications that occur in the dental office. State and federal laws or regulations determine how it is handled, how long it is kept and who may have access to the information. The dental record provides for continuity of care for the patient and is critical in the event of a malpractice insurance claim. This publication will provide some helpful information but the first step should be to review your state dental practice act.

# Dental Records

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## Records Management

The recording of accurate patient information is essential to dentistry. The **dental record**, also referred to as the patient chart, is the official office document that records all diagnostic information, clinical notes, treatment performed and patient-related communications that occur in the dental office, including instructions for home care and consent to treatment.

Protecting health information—and diligent and complete record keeping—is extremely important for many reasons.

First, it can contribute to providing the best possible **care for the patient**. Patient records document the course of treatment and may provide data that can be used in evaluating the quality of care that is provided to the patient.

Records also provide a **means of communication** between the treating dentist and any other doctor who will care for that patient. Complete and accurate records contain enough information to allow another provider who has no prior knowledge of the patient to know the patient's dental experience in your office.

Beyond providing patient care, the dental record is important because it may be used in a court of law to establish the diagnostic information that was obtained and the treatment that was rendered to the patient. It can be used in **defense of allegations of malpractice**. Information found in the record may then be used in determining whether the diagnosis and treatment conformed to the standards of care in the community.

Another way the dental record may be used is to help provide information to appropriate legal authorities that will **aid in the identification of a dead or missing person**. The most common element of forensic dentistry that a general practitioner is likely to encounter is to supply antemortem (before death) records for a **forensic** odontologist.

## Regulations

*State:* A few dental practice acts or regulations issued by state boards of dentistry specify requirements for dental records. In the vast majority of states, however, patient record keeping requirements are contained in laws or regulations that apply to health care professionals in general and also in more generic state legislative/regulations. Check with your state dental society for information on record keeping requirements in your state. To obtain a copy of your state dental practice act, contact either your state's board of dentistry, also known as the board of dental examiners at <http://www.aadexam.org> or go to <http://www.ada.org/ada/organizations/searchcons1.asp> to find a link to your state. Many states post the practice act online and it is now easily accessible. (*Hint:* Google "[name of state] dental practice act.")

### *Your State Practice Act*

Clicking on any state listed below will take you to the licensing institution's Web site for that state.

[Alabama](#): [Alaska](#): [Arizona](#): [Arkansas](#): [California](#): [Colorado](#): [Connecticut](#): [Delaware](#): [District of Columbia](#): [Florida](#): [Georgia](#): [Hawaii](#): [Idaho](#): [Illinois](#): [Indiana](#): [Iowa](#): [Kansas](#): [Kentucky](#): [Louisiana](#): [Maine](#): [Maryland](#): [Massachusetts](#): [Michigan](#): [Minnesota](#): [Mississippi](#): [Missouri](#): [Montana](#): [Nebraska](#): [Nevada](#): [New Hampshire](#): [New Jersey](#): [New Mexico](#): [New York](#): [North Carolina](#): [North Dakota](#): [Ohio](#): [Oklahoma](#): [Oregon](#): [Pennsylvania](#): [Rhode Island](#): [South Carolina](#): [South Dakota](#): [Tennessee](#): [Texas](#): [Utah](#): [Vermont](#): [Virginia](#): [Washington](#): [West Virginia](#): [Wisconsin](#): [Wyoming](#). This can also be accessed at <http://www.ada.org/prof/prac/licensure/index.asp>

## HIPAA/Protecting Health Information

There is a tendency to regard HIPAA regulations for Privacy and Security with apprehension, and not without some justification, as the civil and criminal penalties for violators can be quite stiff. While HIPAA Privacy and Security Regulations are serious matters deserving serious attention and focused implementation efforts, they are no reason to panic and certainly are not intended to discourage the use of electronic transactions by small health care providers.

Two HIPAA regulations, the Privacy Rule and the Security Rule, impact how a dental office uses and maintains its patients' records. Under the HIPAA regulations, dentists who use electronic transactions are referred to as

“Covered Entities”. Most electronic transactions are benefits-related (e.g. claims, eligibility, etc.) communications exchanged between health care providers and health plans via some kind of electronic medium. Voice communications by telephone and most fax communications are not considered to be electronic, at least as far as HIPAA is concerned, but because voice and fax communications may contain individually identifiable health information (“Protected Health Information” or “PHI”), the disclosure of such information must be safeguarded. In the HIPAA context, “electronic” almost always means some kind of computer-to-computer method of communication, either via the internet, private network, a modem-to-modem communication, or physical removal and transportation of a data storage device or medium like a tape, disc, or hard drive. Currently, dentists most commonly perform “electronic transactions” related to electronic claims transactions and electronic eligibility inquiry transactions (whereby dentists can inquire about the status of previously submitted electronic claims).

Use of any one of these transactions, even once, invokes the HIPAA rules regarding electronic transactions with respect to that transaction, which subjects a dentist to HIPAA (although a dentist is always covered by HIPAA with respect to the PHI he or she maintains and transmits). If HIPAA electronic transactions rules do not apply because a dentist does not use electronic transactions, state privacy laws still apply (check with your state dental association!). Even in the absence or relative weakness of state privacy rules, it is still an excellent idea to comply with the HIPAA Privacy and Security Rules. Patients will want to feel that doctors respect their privacy and take care to ensure that sensitive health information remains confidential.

The HIPAA Privacy Rule, which went into effect April 14, 2003, requires covered health care providers, including covered dentists, to protect patients’ PHI, inform patients of their rights under the HIPAA Privacy Rule, provide an accounting of uses and disclosures of information and maintain accurate records of Privacy-related incidents. These topics and more are covered in great detail by the ADA HIPAA Privacy Kit, available from the ADA catalog ([www.adacatalog.org](http://www.adacatalog.org) or call 800-947-4746). With regard to standards for maintaining paper records, the Privacy Rule requires health care providers to make “reasonable efforts to limit protected health information to the minimum necessary to accomplish the purpose of the use, disclosure or request” of the information. These “reasonable and appropriate safeguards/minimum necessary” standards aim to protect information from unnecessary disclosure without inhibiting a health care provider’s core business operations, i.e., treating patients, obtaining payment for services, and legal, financial, and administrative tasks that are all part of running a health care provider’s business. The most reasonable and appropriate safeguards should be determined by the covered health care provider through a careful analysis of risks and available resources to cope with those risks. A safeguard that inhibits timely and effective care, interferes with obtaining payment for services or creates excessive costs and disruptions may be considered unreasonable and unnecessary for a provider with relatively few risks.

For instance, locking file systems are not specifically required by the HIPAA Privacy Rule, but may be necessary to protect access to paper records using, reasonable and appropriate safeguards. Imagine for a moment that a large health care provider (like a hospital) does a risk analysis of its filing system and decides that since some of the cabinets may be vulnerable to snooping, they should be locked at all times. A much smaller provider (like a dental office) may, after performing a similar risk analysis, decide that since its filing system is under staff supervision at all times and that unauthorized persons have no access to its files, there would be no need for the practice to acquire locking file cabinets. Both approaches are correct because health care providers are permitted to tailor their privacy policies to their specific risks and available resources.

As with filing systems, the HIPAA Privacy Rule does not prohibit the use of so-called “allergy alert” or “medical alert” stickers, as such a prohibition may interfere with a provider’s ability to provide timely and effective health care. An office should exercise some caution in its handling of patient records, and the use of generic alert indicators that serve only to prompt caregivers to take a closer look at the patient’s health history may be desirable in many instances.

Dentists have had to comply with the **HIPAA Security Rule** since April 21, 2005. There is a key difference between the HIPAA Security and HIPAA Privacy Rules. The HIPAA Privacy Rule applies to individually identifiable health information in any form, written, spoken, or electronic. In contrast, the Security Rule applies only to *electronic* PHI (“ePHI”) and requires that covered dentists who store health information in electronic form maintain its confidentiality, integrity, and accessibility.

Confidentiality means that the information is available or disclosed to persons or entities authorized to receive it.

Integrity means the information has not been altered or destroyed without proper authorization; if it changes, there is a record of the change and only authorized user can make a change; and finally, that there are means to verify

that data is only changing according to entries made by authorized users. Data integrity helps prevent GIGO (“Garbage In, Garbage Out”) data entry problems and is a safeguard against data corruption, which may be caused by bugs, malware, system crashes, etc.

Accessibility means that data is retrievable under any circumstance. Maintaining data accessibility means sound, thorough business continuity planning.

The American Dental Association published its HIPAA Security Kit to help members comply with HIPAA security regulations and is available from the ADA Catalog ([www.adacatalog.org](http://www.adacatalog.org) or call 800 947-4746).

There is no such thing as a certified “HIPAA Compliant” product, seminar, technology, or design feature that is effective “out-of-the-box” for all dentists in all circumstances because of the scalable, technology-neutral nature of the Security Rule. Covered dental offices must determine the most reasonable and appropriate safeguards for their particular circumstances and risk profile.

With regard to electronic security standards required by HIPAA, it is essential that any electronic health record be accurate, easy to retrieve under any situation, and that some means of tracking who made changes and when is always available. More information on this can be found in the ADA’s *HIPAA Security Kit*, available through the *ADA Catalog*. Your office may need to consult with your software system vendor for assistance in completing tasks related to maintenance of electronic records.

Dental offices subject to HIPAA should have policies, procedures and forms for HIPAA compliance. Your entire office should stay current and informed about HIPAA and state laws regarding the privacy and security of PHI and ePHI. This informational resource is not intended to comprehensively cover all HIPAA related questions.

For additional information on HIPAA privacy, go to <http://www.ada.org/prof/resources/topics/hipaa/index.asp> or order The HIPAA Security for Dental Professionals Seminar DVD, or the ADA’s *HIPAA Privacy Kit* and the *HIPAA Security Kit*. You can order these products by contacting ADA Catalog, 1-800-947-4746, or visiting the ADA Catalog’s Web site, [www.adacatalog.org](http://www.adacatalog.org).

### *Common Sense Privacy and Confidentiality Steps<sup>1</sup>*

- Avoid leaving patient information where others can read the content – whether on paper or electronic. Charts should not be left out in public areas. Confidential information should be marked as such and protected from view of others. Try to keep computers reflecting patients’ information out of view, or use screen savers or other methods to protect the information as reasonably as possible.
- Avoid asking patients sensitive questions where other patients can hear the conversation.
- Avoid discussing confidential patient information with other dental team members where other people can hear the conversation.

### Organization of Dental Records

Most dentists make notes in paper dental records. However, more and more dentists are making use of computerized filing systems to maintain patient dental records. Electronic records have great quality and patient-safety benefits, and will likely increase as more dental offices become computerized. Because many dental offices use the traditional paper charts, traditional filing systems are discussed first.

Generally, patient records are housed in file folders for protection. These files are labeled with the following information (in the following order):

- Patient’s surname;
- Patient’s first name;
- Patient’s middle name; and
- Patient’s degree or seniority (i.e., Senior, II).

The files are then arranged in a way for easy retrieval—usually in a lateral, open-shelf filing system.

### *Color Coding*

Many dental offices use a color-coded filing system for patient record files. Color-coded labels—usually the first two letters of the patient's last name and active date of treatment—are placed on the patient's file. This can help make record retrieval fast and easy.

### *Active and Inactive*

Most offices have two categories of patient records files: 1) Active and 2) Inactive.

Active files hold the records of patients currently having their dental care provided by the practice. Inactive patients are considered to be those who have not returned for 24 months. Keep files of active patients on-site. These records should be conveniently located in the office.

Inactive files hold the records of patients who have been treated in the office in the past but are not currently under care in the office. These files are generally located in the office, but in a remote area.

As defined by policy of the American Dental Association, (Trans. 1991:621), an active dental patient of record is any individual in either of the following two categories: Category I - patients of record who have had dental service(s) provided by the dentist in the past twelve (12) months; Category II - patients of record who have had dental service(s) provided by the dentist in the past twenty four (24) months, but not within the past twelve (12) months. An inactive patient is any individual who has become a patient of record and has not received any dental services(s) by the dentists in the past twenty four (24) months.

The above definition is typically used in practice appraisals and may not be the same definition of an active patient used in a dental office in records maintenance.

A system should be established in your office to identify a change from active to inactive status on a timely basis. All records, active and inactive, should be maintained carefully to be certain that they are not destroyed or lost.

## Content of the Dental Record

The information in the dental record should primarily be clinical in nature. The record includes a patient's registration form with all the basic personal information.

The dental team should be very meticulous and thorough in the dental office recordkeeping tasks. All information in the dental record should be clearly written, and the person responsible for entering new information should sign and date the entry. The information should not be ambiguous or contain many abbreviations. In practices with more than one dental practitioner, the identity of the practitioner rendering the treatment should be clearly noted in the record.

All entries in the patient record should be dated, initialed and handwritten in ink and/or computer printed. While no specific color of ink is required, any copy of the record should be easy to read. Handwritten entries should be legible. If a mistake is made, do not correct it with "white-out." A single line should be drawn through the incorrect info, the new corrected info added, and again, the entry should be signed and dated.

The following are examples of what is typically included in the dental record:

- database information, such as name, birth date, address, and contact information
- place of employment and telephone numbers (home, work, mobile)
- medical and dental histories, notes and updates
- progress and treatment notes
- conversations about the nature of any proposed treatment, the potential benefits and risks associated with that treatment, any alternatives to the treatment proposed, and the potential risks and benefits of alternative treatment, including no treatment,
- diagnostic records, including charts and study models
- medication prescriptions, including types, dose, amount, directions for use and number of refills
- radiographs
- treatment plan notes
- patient complaints and resolutions

- laboratory work order forms
- mold and shade of teeth used in bridgework and dentures and shade of synthetics and plastics
- referral letters and consultations with referring or referral dentists and/or physicians
- patient noncompliance and missed appointment notes
- follow-up and periodic visit records
- postoperative or home instructions (or reference to pamphlets given)
- consent forms
- waivers and authorizations
- conversations with patients dated and initialed (both in-office and on telephone, even calls received outside the office)
- correspondence, including dismissal letter; if appropriate

No financial information should be kept in the dental record. Ledger cards, insurance benefit breakdowns, insurance claims, and payment vouchers are not part of the patient's clinical record. Keep these financial records separate from the dental record.

Other information best left out of the record would be personal opinions or criticisms. Stick to facts, especially those related and relevant to providing dental care. Imagine what you write in a record being read in a court of law (remember that this is a legal document). Do document a patient's refusal to accept the recommended treatment plan and cancelled appointments.

The outside cover of the chart should only display the patient's name and/or the account number, unless more is required by state law or you need to flag a chart on the outside cover. If this is the case, use an abstract, in-office system (color or symbol coding) so that only your office staff will be able to decipher it.

For all offices, but especially those subject to HIPAA, a single sticker on the outside cover can alert the team to look on the inside for important information regarding allergies, medications, antibiotic pre-medications, and clinical conditions that can affect dental treatment. All medical notations belong inside the chart for only authorized personnel to see.

Your professional liability insurance company and or personal legal counsel may have additional recommendations. Many insurance companies make this information readily available on their Web site or may be contacted for the information. A list of professional liability companies is available on ADA.org (<http://www.ada.org/>).

## Retention and Storage

State laws and participating provider contracts generally specify the time following the last patient visit that records must be maintained. There is usually a different requirement for the retention of records of children; these records must be kept for a certain period after the child reaches the age of majority. HIPAA also affects recordkeeping requirements for offices that are covered by generally requiring that such offices maintain patient records for six (6) years and two (2) years after a patient's death. The dental office should have a records retention policy and all staff should understand it. The office's professional liability insurance company will likely have recommendations about retention.

In a multi-practitioner practice of any nature, determining the party responsible for maintaining the original patient record of any patient treated at the practice facility may be dependent on the type of professional corporation (PC) or structure of the practice. Unless the agreement specifies differently, the professional corporation would likely be considered the owner of the dental record, whether paper or electronic. This applies whether or not the owner was involved in the patient's treatment.

If the structure of practice is an office-sharing arrangement and the dentist is an independent contractor rather than practice employee, each dentist would likely be considered as practicing under a separate legal entity, whether a PC, limited liability company, partnership or sole proprietorship. Associate agreements, either for employee associates or independent contractors, should include language that specifies the associate's access to patient charts and ownership issues.

State law may also specify the obligations of buyer and/or seller regarding record ownership, maintenance and/or retention in the event of a practice sale. If the practice has been sold, the sales agreement itself may spell out the terms for record retention and access.

If space for records becomes a problem, dental records may be preserved on microfilm or microfiche, stored with a records storage service (fairly common in many jurisdictions) or scanned for electronic storage. The great benefit of storing records electronically or on microfilm or microfiche is that they take up less space than paper records. Diagnostic and/or treatment casts may be photographed and stored in some cases. However, prior to completely converting records to one of these methods, a dentist should consult with his/her own attorney and professional liability insurance company. In those dental offices that are considered covered entities, a HIPAA business associate agreement may be required if outsourcing records storage. Again, state law must be followed. State law can be quite specific on regulations related to health care recordkeeping.

## Health/Dental History

The accurate health/dental history may provide important and valuable information for the dentist prior to beginning treatment. All dentists should take health histories initially and update the same periodically as necessary.<sup>2</sup> A health history form can address:

- health conditions or illnesses that may affect or be affected by dental treatment;
- medications that a patient is currently taking that will have a potential drug interaction with the local anesthetic or other drugs the dentist may prescribe that may affect dental treatment or a patient's other health condition(s); and
- reason a patient is seeking care.

Dentists have a responsibility to obtain and maintain current health histories of patients. Team members are most often responsible for having patients complete their health/dental history forms but that is only part of the process. It is also important that a patient understands the questions, provides answers where appropriate and sign the completed form. Patients should be encouraged, if they do not understand the form, to discuss it with the dentist or office staff. A health history form provides a starting point for the dental team to fulfill its professional obligations.

Once a patient has completed the questionnaire/health history, it is recommended that the patient's health information be reviewed carefully. The dentist should review and discuss the form with the patient, then sign or initial the form once this review is completed. Interviewing the patient is an important part of the medical history taking process and space should be provided on the medical history form for recording findings gathered during the interview.

The dentist should be prepared to answer any questions that a patient may have regarding the form. No questionnaire addresses every aspect of a patient's health. For example, additional or more focused questioning may be appropriate for patients with specific health concerns. The interaction between the dentist and dental team members, during the health history process, can be equally or more important than the form itself.

### *Updates to Health History Form*

A patient should be questioned at each visit to determine if the health status or medication taken has changed. The record should have a dated notation that the patient was asked about recent health and medication changes and any changes should be updated in the patient's record. A patient's medical status should be monitored at intervals appropriate to the patient's age and medical history.<sup>3</sup> The decision about the frequency is professional, not legal. Your professional liability insurance company and/or attorney may be consulted for more information.

The ADA Catalog (<http://www.adacatalog.org> or 1-800-947-4647) also offers both an adult and a child's health history form, both available in English as well as Spanish. These particular questionnaires need not be used by all dentists, and may or may not lead to compliance with all applicable laws.

### *Health History Forms in Multiple Languages*

With the increasing diversity in patient populations, it may be desirable to provide a health history form in multiple languages. The University of the Pacific Dental School in California and Met Dental have both supported the development of a free downloadable standard health history form in over 21 languages, available at:

<http://dental.pacific.edu/DentalPro/historyForms.htm>

University of Pacific Web site includes instructions for use. Be sure to download the English version too. The questions and sequence for all languages correspond to the English version.

## Who Makes Entries in the Record?

Attorneys and doctors debate who should make the entries in the dental record, but state law will determine this in most cases. Keep in mind that the dentist is ultimately responsible for the patient's chart.

Some entries may be delegated to office staff if allowed by state law. The administrative assistant can record telephone calls; prescription changes; and canceled, changed, and failed appointments. The dental assistant records the patient's comments, concerns and disposition; vital signs; medical history notations; radiographs and other diagnostic tools taken and used; and instructions given to the patient, etc. Dentists add clinical impressions, treatments performed and any pertinent information. All entries should be initialed and/or signed by the team member writing the entry and the dentist.

If the dentist opts not to make his or her own entries, he/she should dictate what to write to the assistant. The dentist should review the contents of the entry as soon as possible for accuracy and then sign or initial it.

## How to Write in the Record

Always think before you make an entry, especially if the remarks are complex in nature. You may want to jot down some of the facts on a piece of paper and then transcribe them in an organized way into the record. It is best to document while the patient is still in the office, or as soon as possible after the patient leaves. The record is the single most important source of evidence in a liability claim. All entries in the patient record should be dated, initialed and handwritten in ink and/or computer printed. While no specific color of ink is required, any copy of the record should be easy to read. Be aware that if different colored ink is used by staff members (i.e., the hygienist's uses red ink); this coding method will not appear on a copy of the record unless a color copier is used. Handwritten entries should be legible.

Make sure all of your entries are objective in nature. Confine your comments to necessary information about the patient's treatment. A patient has a right to request to see their record (including "personal notes" you may keep in a separate chart). Keep in mind that in the case of a malpractice claim, the record could appear in a court case and a judge and jury could read your notes. Imagine the record magnified and displayed in a courtroom. Stick to facts, especially those related and relevant to providing dental care.

Be sure that any attachments are included in the patient's record, especially radiographs. It provides a resource for the dentist to evaluate the short-term and long-term results of treatment performed, the cooperation of the patient and the effects of any complicating factors. Do document a patient's informed consent for treatment. Should a patient refuse to accept the recommended treatment plan, notate the patient's reasons for refusing care in the record. Consult your attorney or liability company for additional steps that should be undertaken when a patient refuses treatment. More information on informed consent and informed refusal can be found in the member section of the ADA Web site (<http://www.ada.org/>) under the topic "Informed Consent".

### *Use of Abbreviations and Acronyms*

If you must use abbreviations or acronyms, make sure they are in common use (or can be easily explained) in your practice and avoid their overuse in record keeping. Those that are used should be clearly understood by those employees in the office with access to the record. Avoid the use of arcane symbols in record keeping. Also be aware that such usage could delay identification in a forensic investigation. It is a good idea to have a universal "key" readily available to all staff, or included in the chart, providing definitions for all abbreviations and acronyms.

### *Corrections or Alterations*

There are times when it is necessary to make a correction. There is nothing wrong with a correction if handled properly. Some state laws may allow you to simply cross out the wrong entry with a thin line, and make the appropriate change. Date and initial the each change or addition. **Never obliterate an entry.** Do not use markers or white-out. The important factor is that you must be able to read the wrong entry.

Do not leave blank lines between entries with the intent to add something at a later date. It could be construed as an alteration. Do not insert words or phrases in an entry; this could be construed as an alteration. If you remember something you wish to record at a later date, just make the entry chronologically and refer to the date of the visit in question.

Professional liability insurance companies have long asserted that errors or inadequacies in the patient record prevent them from successfully defending some dentists against unfounded allegations of malpractice. To identify where there is the greatest need for improvements in record keeping, a 2005 survey conducted by the ADA Council on Members Insurance sought to determine the frequency, severity and causes of dental malpractice claims reported between 1999 and 2003. The survey is available on <http://www.ada.org>. The following question was posed to the insurers with respect to both general practitioners and specialists:

Please indicate the degree to which your company has noted the following types of problems with its insured's' patient records (whether or not the problem was a primary cause of a paid claim.)

To quantify the responses to this subjective question, a value of ten was assigned to any problem that was indicated as being "very common." If a problem was "fairly common," it was assigned a value of five. If the insurer said that the problem was "not common," it was assigned a value of zero. The average scores for each problem, reflecting the opinions of fourteen insurers weighed equally, are listed below:

<b>Insurers Views as to the Frequency of Various Record Keeping Errors</b>	
<b>Type of Error in Descending Order of Frequency</b>	<b>Average Score</b>
Treatment plan is not documented	6.5
Health history is not clearly documented or updated regularly	6.1
Informed consent is not documented	5.9
Informed refusal is not documented	5.0
Assessment of patient is incompletely documented	4.9
Words, symbols, or abbreviations are ambiguous	4.9
Telephone conversations with patient are not documented	4.6
Treatment rendered is not clearly documented	4.5
Subjective complaints are not documented	4.1
Objective findings are incompletely documented	4.1
Treatment plan is not supported by documented subjective and objective findings	4.0
Reasons for deviation from the original treatment plan are not documented	3.9
Patient non-compliance or failed appointment(s) are not documented	3.7
Records are not legible	3.7
Routine full-mouth periodontal probing not documented	3.4
Insufficient records given the complexity of the issue	3.2
Post-operative instructions are not documented	3.2
Referral to or consultation with another practitioner or physician is not documented	2.8
Comments about the cost of treatment and the patient's payment history	2.6
X-rays were inadequate for the procedure	2.3
Prescription orders are not documented	2.2
Deletions, additions, or corrections are not made properly	2.0
Risk management notations included in the chart	1.4
The name and relationship of the person who gave consent is not documented for minors or patients who are incapacitated	1.4
Alteration of records	1.1
Lost records/X-rays	.7
Records are not written in ink	.7
Record contains notations relating to discussions with an attorney or insurer regarding a possible malpractice lawsuit	.4
Critical or subjective personal comments about the patient in the chart	.4

These results indicate that, in the opinion of professional liability insurance companies, it is fairly common to find that their dentists that have presented claims are not adequately documenting treatment plans, the patient's medical history and the informed consent/refusal process. Whether this result is indicative of the need for improvement in record keeping among all dentists is conjectural. However, the Council believes all dentists should review their own record keeping practices to identify whether any of the issues shown in the survey need to be addressed.

## Ownership (see also Retention and Records section for multi-practitioner practice)

The dentist owns the physical record of the patient. He/she is the legal guardian of the chart. Patients do not have the right to possess their original record. They do have the right to see, review, inspect, request, and obtain a copy of their record. The dental team should be aware of HIPAA and the laws of their particular state governing this issue. If the patient requests a copy, the dentist is obligated to provide those records (including radiographs) within a reasonable time frame, which may be specified under state law.

In most cases, reasonable, cost-based fee may be charged for copying records. The fee should be limited to cost of supplies and labor for copying and postage (if mailed). However, state laws vary widely on this issue and may specify a limit on what can be charged. Federal HIPAA regulations generally preempt state law but state law may have a more prescriptive restriction on fees that can be charged.

*Do I have to give a patient a copy of his or her records if the patient hasn't paid his or her bill?*

Yes, under HIPAA privacy regulations and quite possibly under your state law as well. Your office will most likely have customized policies and procedures for HIPAA compliance in place. Due to the confidential nature of the dental record, before you send out any copies to either the patient, a patient representative and/or another provider, make sure that you have necessary permissions. Under HIPAA, this refers to an "Acknowledgment" form (and perhaps subject to the "minimum necessary standard"), and in some cases, a specific "Authorization" form. Some states may have more strict requirements. In addition, only send, or copy, the portion of the patient record that is requested. Prompt transfer to another practitioner can avoid any interruption of care for that patient.

*"A dentist has the ethical obligation on request of either the patient or the patient's new dentist to furnish, either gratuitously or for nominal cost, such dental records or copies or summaries of them, including dental X-rays or copies of them, as will be beneficial for the future treatment of that patient. This obligation exists whether or not the patient's account is paid in full."<sup>4</sup>*

Dentists also own radiographs; since they are an important part of the clinical record made by the doctor and cannot be interpreted by laymen. Patients do have the right to obtain copies of their radiographs.

## Transfer or Copies of Records

Due to the confidential nature of the dental record, before you send out any copies either to the patient, a patient representative and/or another provider, make sure that you have necessary permissions. Under HIPAA, this refers to an "Acknowledgment" form (and perhaps subject to the "minimum necessary standard"), and in some cases, a specific "Authorization" form. Some states may have more strict requirements.

Your office will most likely have customized policies and procedures for HIPAA compliance in place. In addition, only send, or copy, the portion of the patient record that is requested.

*What permission, if any, must a patient give to transfer records?*

This depends on whether you are covered by HIPAA, your state law and also on the specifics of the case. Because of the confidentiality of the dental record, it is important to make sure you have the necessary permissions before you send out any copies, either to the patient, a patient representative and/or another provider.

## Release Form

A simple release form for release of the record to either the patient or another health care provider may be signed by the patient and become a part of the dental record. This release form, signed by the patient, should specify to whom the records are being delivered and identifying the records. Signing such a form is generally not required by HIPAA to send records to another health care provider, but in some states consent is required before releasing

health information. Check with your state dental society about what is required in your state. Your professional liability insurance company may also consider such a release a component of good record keeping.

#### *Who Can Consent to the Release?*

State law may determine the permission needed to release medical record information. Generally, the authority to release dental information is granted to: (1) the patient, if a competent adult or emancipated minor; (2) a legal guardian or parent if the patient is incompetent or a minor child; and (3) the administrator or executor of the patient's estate if patient is deceased. The patient's right to authorize release of dental records is codified in many state statutes. These statutes all state that dental records are confidential and cannot be disclosed, except in specifically provided circumstances. However, the extent of the patient's right to access varies from state to state. Some states allow the health care professional or provider to determine patient's right of access. In comparison, some states expressly grant patients access to the dental information contained in their dental records.

General releases may not suffice for records containing HIV or other sensitive material. Most state laws prohibit the disclosure of HIV status test results to a third party without a specific written authorization by the patient or the patient's representative. Any information regarding health issues should be handled with caution and special regard for the patient's privacy. Even if appropriate authorization and consent is received, dentists and other health care professionals may be legally precluded from releasing HIV/AIDS records without specific reference to that information in the release. Some states have heightened confidentiality provisions for sensitive information, such as HIV status.

Typical elements of a valid general release include:

- Patient's name and identifying information;
- Address of the health care professional or institution directed to release the information;
- Description of the information to be released;
- Identity of the party to be furnished the information;
- Language authorizing release of information;
- Signature of patient or authorized individual; and
- Time period for which release remains valid.<sup>5</sup>

When sending records, make a notation in the patient's chart as to the date, where and to whom the copies were sent. There may be office policy restricting sending anything out of the office without the dentist's knowledge and approval. By using certified return receipt requested U.S. Postal Service or another service that provides proof of delivery, you will be able to prove the records were sent. Keep copies of certified receipts or proof of delivery in the chart.

#### *Should original records be sent when a copy is requested?*

Never release original records to anyone but rather send copies, including radiographs. There is one exception: you may send the originals if you are required to do so by a government agency with proper authority, such as a court order, or in some states, a subpoena. If this situation were to occur, you should make copies for your office.

#### *Are there exceptions when information in a dental record would be disclosed without a patient's consent?*

Below are exceptions that allow disclosure without consent, for these purposes:

- Defense of a claim challenging the dentist's professional competence; peer review process
- Claim for payment of fees
- Third party payer relating to fees or services furnished
- Court order to a police or federal agency as part of a criminal investigation
- Identify a dead body
- Report a legal violation of another health care professional if the dentist reasonably believes it is necessary to disclose the information to comply with Public Health Code<sup>6</sup>

Under HIPAA, covered entity dentists who are otherwise in compliance with the law may transfer records for certain purposes without the patient's explicit permission. For example, covered entity dentists may share records with other health care providers for treatment purposes and transfer patient records to dentists who are purchasing their practice. Also, covered entity dentists may share portions of the patient records as needed to obtain payment for their services. However, disclosures of this type must be limited to "minimum necessary" amount that must be shared for the intended purpose (i.e., obtain payment).

In response to a valid court order, HIPAA regulations (and possibly state law) may not require an authorization to release a patient's record. However, if the subpoena is not accompanied by a court order, the subpoena alone is not a valid basis to disclose the information (unless a subpoena has the force of a court order under state law). Because these situations are complicated and require careful analysis, check with your state dental society or attorney about what is required.<sup>7</sup>

The ADA in 2007 updated its *General Guidelines for the Referral of Dental Patients*, included as an Appendix in this publication.

## Informed Consent

What exactly is informed consent? In general, it is required that dentists provide information to patients about the dental health problems that the dentist observes, the nature of any proposed treatment, the potential benefits and risks associated with that treatment, any alternatives to the treatment proposed, and the potential risks and benefits of alternative treatments, including no treatment. Some procedures call for a separate consent form to be signed, but there are many times when procedures and options are discussed and a consent form may not be utilized. In some offices, notes of the discussion with the patient are entered in the record at the time the discussion is held and the patient is asked to initial the entry.

The dentist must secure informed consent before providing care. The exact requirements vary by state and by the type of procedure being performed. Certain procedures, such as invasive or requiring extensive treatment, should have a signed, written informed consent. In those cases, the appropriate staff person should be sure that a signed written consent form has been obtained before the treatment is provided. Your practice's professional insurance company and/or attorney may also have recommendations and resources, such as sample forms.

Consent for treatment provided to children or an incompetent adult requires special consideration.

The dental record should contain a notation concerning the granting of informed consent to do the treatment proposed, or that consent was not granted (and treatment not done).

## Informed Refusal

If the patient refuses the proposed treatment, the dentist must inform the patient about the consequences of not accepting the treatment and get a signed informed refusal. However, obtaining an informed refusal does not release the dentist from the responsibility of providing a standard of care. If, for example, the patient refuses to have radiographs taken, the dentist should refer the patient to another dentist when the original dentist believes that radiographs are a necessary prerequisite to proper care in that case.

Obtaining informed consent/refusal can involve complex issues. You may wish to take continuing education courses on this subject.

## Use of Social Security Number

With identity theft occurring at escalating rates, you may find many patients reluctant to provide their social security number (SSN). There are legitimate reasons to ask patients for social security numbers. For example, these numbers may be helpful in determining if the patient is credit worthy. If patients are not financing their dental care, and the number is not needed to file a claim for a dental benefit program, you may not need the patient's social security number. Many third-party payers have created unique IDs for this reason. Your practice may wish to consider using a unique patient ID other than the Social Security number (SSN).

There is a law in California that restricts the use of SSNs in some circumstances. This law restricts businesses and state and local agencies from publicly posting or displaying Social Security numbers. It also bans embedding SSNs on a card or document using a bar code, chip, magnetic strip or other technology. The law takes effect gradually, from 2002 through 2007. The CA Office of Privacy Protection has a good summary of that law, <http://www.privacy.ca.gov/recommendations/ssnrecommendations.pdf>.

## Destruction

If your office decides to destroy records as allowed by state law, caution must be used in the destruction of records. Confidential information is included in the dental record. You have an obligation to protect the patient's privacy and personal health and financial information.

For those inactive patient records (passed the Statute of Limitation) that will not be transferred or returned to patients, a more secure way of eliminating these unwanted records generally involves shredding. There are professional shredding services available to do this for you. You could also rent an industrial-grade shredder and destroy the records yourself. Small paper clips and staples generally do not have to be removed prior to professional shredding.

Many medical facilities outsource the destruction of records. To find such a service, check in the Yellow Pages or use an Internet search under a topic such as "document destruction." A professional shredder service should sign your confidentiality agreement (or HIPAA "Business Associate Agreement," if applicable) and if they will agree, indemnify you in the event of a breach in confidentiality. Most services issue a Certificate of Destruction or the company may allow you or a staff member to witness the destruction. You may wish to check with personal legal counsel before destroying records.

NAID (National Association for Information Destruction, Inc.) claims that it is the international, non-profit trade association for the information destruction industry. Membership includes companies (including suppliers) and individuals involved in providing information destruction services. See <http://www.naidonline.org/> for further details if you need a commercial shredder firm. You might get recommendations for such a service from a larger health care provider in your area, such as a hospital.

**CAUTION:** Do not burn patient records containing radiographs as the heat could release dangerous metals. Silver recovery by a professional recovery firm might be a better option that pays you for recovering the silver content from x-rays. Check your telephone book or with your state or local dental society for a silver recovery firm or certified waste hauler.

Paper re-cycling is not a good option if you have to get rid of inactive paper dental and business records in order to close a practice. Under most circumstances, recycling companies merely collect then sort paper that comes to the company. In general, the collected paper is bound and sold to the highest bidder weeks or months later (even years later). There is no guarantee of confidentiality and there is no way to ensure just when the paper, potentially containing confidential or sensitive information, was destroyed.

Recycling without destroying patient records for a retiring dentist closing his/her practice and improperly disposing of the records might be viewed as negligent by the court in the event of an allegation of breach of confidentiality or in the case of a federal complaint to the Department of Health and Human Services Office of Civil Rights (for a supposed HIPAA violation by a covered entity) as an illegal practice under the Act. In either case, recycling without documentation of destruction is an example of poor risk management.

Always insist on a certificate of destruction; furthermore, make sure that there are no sub-contractor companies involved which do not also agree in writing to adhere to the privacy policies of the practice.<sup>8</sup>

## Access

Only authorized persons should have access to office records. Be sure the dentist has an office policy on this matter, and you understand and abide by that policy. Patient records should not be removed from the dental office without the knowledge and permission of the dentist.

Today, many dentists are still using paper patient records stored in file cabinets and shelves. Increasingly, dentists are incorporating new technologies into their practice to manage the large number of existing records. This information may also be stored on an off-site server that is shared with other users and accessed on a network.

The security of access to digital records and the costs of maintaining a system continue to be a concern. But with today's access technologies featuring fingerprinting, retinal scanning, electronic signatures, and voice recognition,

records can be as safe as paper records if managed properly. Data encryption, a process in which data is scrambled before transmission then reconfigured with a special code by the end user, also adds security. The HIPAA Security regulation requires implementation of security measures to patient health information, such as:

- Administrative safeguards such as security policies and procedures
- Technical safeguards such as password protections and back-ups of patient records
- Physical safeguards, such as limiting access to PHI

## Electronic Patient Records

The use of electronic records is dramatically affecting the dentistry profession. As a member of the administrative dental team, you must also take the initiative to learn the terms and the tools of the new electronic world—especially with regard to electronic records and HIPAA regulations.

Digital technology, the advancement of networked computing and the digitization of information, will continue to change the profession of dentistry in numerous ways—from the clinical to continuing education and, from practice management transactions such as payment and marketing to e-commerce.

Software programs allow electronic transmission of patient records with sound, text and images to dental specialists for second opinions and preauthorization for insurance purposes. Instead of written descriptions with tooth charts, digital clinical photographs may be attached. For more information on HIPAA Security regulations related to electronic records and communications, consult the ADA *HIPAA Security Kit* available for purchase through the ADA Catalog.

### *Communicating with Patients by E-mail*

Electronic communications use in the dental office can be very beneficial. For example, it can help the dentist save time, and put an end to phone tag with patients. For patients, it may help them compose more detailed questions for the doctor and complete tasks such as scheduling appointments or refilling a prescription.

However, using e-mail for patient care purposes can also raise significant considerations. It is difficult to ensure confidentiality and to confirm the identity of the person when communicating via unsecured e-mail. E-mail could be misdirected in error, or forwarded to an unknown third party without proper controls. Patients should be made well aware of these risks and agree to accept them before use of electronic communications.

But will a patient's acceptance be a binding release? If patients agree, how will these communications be incorporated in the dental record? Can you minimize your exposure/risk or lessen your liability for business you conduct online? And, are you insured? Answers to these and many other open questions will take time to evolve, as users get more familiar with emerging technologies, and the courts grapple with how to resolve bad outcomes arising out of their use.<sup>9</sup>

### *Making the Transition to a Paperless Office*

Digital patient records are an increasingly common practice management tool as technology advances and become more effective.

During the transition from a paper dental office to an electronic one, manual filing and record keeping continue to be extremely important. Dentists should educate themselves as to the legal, ethical, and technological issues that are related to an electronic medium — including whether state law mandates backup paper record keeping. Some states may have “quill” laws that fail to recognize certain types of electronic records as valid in legal proceedings. Carefully check laws related to electronic record keeping as changes in this area occur rapidly.

Even with advancing technologies, practitioners and staff must realize that the transition to “paperless records” is not seamless, totally safe, or problem-free and may not eliminate the need to keep paper records due to legal requirements in some states.

No matter what precautions are taken, there is still a possibility that someone might gain access to stored electronic information. Computer viruses and other computer hardware and software problems can cause information to be lost, as well.

An increasing number of dental offices are using electronic communication and information technologies. The field of dental informatics, “the application of computer and information science to improve dental practice, research, education, and management,”<sup>1</sup> is emerging to work with computer science and telecommunications to bring all of these concepts into workable tools of the future. Dental informatics is helping to develop ways to implement the “sharing” of medical information, yet keep it from unauthorized individuals and comply with HIPAA and other legal requirements.

Interprofessional communications will improve, as dentists will be able to consult more quickly and in greater detail electronically with other healthcare professionals such as physicians, radiologists, pharmacists, psychologists, and nutritionists to deliver the best possible dental care.

## National Health Information Infrastructure

How the dental practice manages dental records will change rapidly in the future. There is currently a new initiative to create electronic health records for patients that could be accessed by all health care providers. The goal is for patient records to be available to all health care providers electronically, virtually anywhere in the country, through an interoperable system.

Scheduled for completion in 2015, the National Health Information Infrastructure (NHII) will be a communications system comparable to a network of highways, roads and pathways on which all health information will travel. Its purpose is to enable patients' electronic health records to be accessed and added to by all health care providers electronically (with patient authorization), virtually anywhere in the country, via the network. The electronic health record will include health information entered for a specific patient at a specific point of service. It will travel and be accessible on the NHII.

Falling under the purview of the Department of Health and Human Services, HHS envisions regional collaborations among health care entities, including dentists and other health care practitioners, so that a patient's information can be securely stored in the local community and made electronically accessible to all health care providers involved in treatment of a particular patient.

For updates on this evolving topic, go to the American Dental Association Web site, <http://www.ada.org>.

## Record Handling When Closing a Practice

Some states have specific record retention and patient & employee notification requirements that apply whenever a dentist decides to retire or close a practice (i.e. Florida's Administrative Rule 59Q-17.001 Required Availability of Dental Records Upon Relocation or Termination of Practice, or Death of Practitioner). Check with your state or local dental society for specific information or with an attorney who knows about the requirements in your state. For contact information in your state, go to the constituent (state) dental organizations list on <http://www.ada.org/ada/organizations/searchcons1.asp>. All constituent dental societies have Web sites and many provide a link to the state dental practice act.

Patient records must be handled in accordance with applicable laws. However, in most states, a dentist is usually allowed to charge a patient a reasonable fee for duplicating and transferring records to another practice. Under a circumstance of retirement, many dentists provide this service free of charge. They should not refuse to release needed patient treatment information due to the payment delinquency of the patient. Failure (or refusal) to release necessary information to another dentist for a patient's continuing care may be illegal and may be viewed as an unethical practice by your professional association.

If possible, the dentist who is planning to close a practice should notify patients well in advance that the practice is closing. In most states, letters to patients of record or an announcement in a community newspaper are ways in which a dentist might give advance notice of a closing. Notice of 30 - 60 days is sufficient for most patients and circumstances.

Patients should be notified how to obtain a copy of their dental records, notified of the location they are stored or given the option of transferring records. This notification can be by letter and have wording such as:

At your request, copies of the pertinent information from your record can be made available to a dentist of your choosing. If you wish to make a request regarding your patient record, please contact the office before the permanent closing day, as your written authorization is needed to make your records available to another dentist. After that day, you will have to direct your inquiry about the record to (name of dentist or record custodian), located at (complete address, phone number).

Your states' laws actually govern whether a dentist must send originals, however, in most cases, the practice should only send copies of a patient's record to another dentist, and only with the patient's or their representative's (e.g. a legal guardian) permission. Make a note of where copied records are sent. Unless your state laws direct otherwise, original records should remain with the retiring dentist (or with the surviving spouse or his/her legal representative, since a dentist's estate can be sued years after a dentist's death) in accordance with a state's record retention laws.

A proper patient transfer from a retiring dentist who must discontinue treatment in advance of completion may have at least these four requirements: 1) identifying a skilled practitioner who will accept the unfinished case; 2) providing that dentist with necessary clinical information so that he/she knows enough about the patient to continue or alter treatment, if necessary; 3) the patient agreeing to the referral; and 4) the patient actually submitting to the treatment in a cooperative fashion. Short of achieving all four, a dentist could still have trouble defending against an abandonment allegation, depending on applicable law.

Remember of course, that record retention is a matter of state law and risk management. In general, records may be destroyed for inactive adult patients who have not been seen in seven years (longer in some localities) or at the expiration of the statute of limitation on contract and tort actions. The oral health record of inactive minors generally should NOT be destroyed until seven years after a child reaches majority (21 years plus 7 years, or 28 years of age in some localities). Always check your local law. Records should be stored in a moisture and fire resistant container. Check with your attorney or state dental association to learn the record retention requirement in your state and with your insurance company for risk management recommendations. (See section on Destruction).

## Record Handling During Sale of a Practice

When selling a practice, three main methods are available to the dentist for a transfer of patient records:

1. The dentist may choose to keep the original patient documents and provide the buyer with a copy of all the patient charts and radiographs. This method would provide the dentist with the best protection in the event of a future malpractice claim, since the old records would be maintained by the seller.
2. The dentist may choose to keep copies of all the patient charts and provide the original records to the buyer. This method may not give the seller the same liability protection as in the previous method.
3. The dentist could obligate the buyer, in the sales contract, to allow the seller access to the records in the event of need. The buyer is typically required to maintain these records for a set period of time after the sale. Further contract language regarding damages for records not maintained could be included. The disadvantage of such a transfer is that even with this provision, the buyer may inadvertently destroy or lose records or make access difficult. In evidence law, there is nothing better than the original document and, therefore, be sure it can be obtained in the event of a question or a professional liability claim.<sup>10</sup>

The sales agreement clause related to patient records would typically permit the seller for a specified period of time to have access to the patient charts, records and x-ray file in connection with the practice sale transaction to allow review and making of copies for defense of malpractice litigation or to respond any inquiries from licensing or regulatory authorities.

## Releasing the Oral Health Record in Emergencies or Forensic Investigations

### *HIPAA Privacy Rule and Release of Protected Health Information*

Dentists who are covered under the HIPAA Privacy Rule generally may release dental records or make disclosures from the record to law enforcement officials under the regulation without patient authorization provided they present a valid, properly served warrant; court order, subpoena or administrative request. In the case of an

administrative request two conditions generally must be met: 1) the information sought must be related to a legitimate law enforcement inquiry; and, 2) be reasonably limited to the scope of that inquiry. The HIPAA privacy regulations also permit dentists covered by the Rule to release patient records and make disclosures to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by state law.

Under HIPAA, a covered entity may use professional judgment to determine when it is appropriate to release clinical records to a family member for identification purposes since the HIPAA regulations indicate that such disclosures may need to be limited to directly relevant information. The most prudent option might be that the dentist, in consultation with his or her attorney, limits a disclosure to just those records or data necessary for victim identification.

Depending on the circumstance of the request, the celebrity of the patient for example, prior to release, a dentist (or the Privacy Officer in a dental practice) might wish to seek permission from the person(s) named in the record as next of kin.

A dentist may need to collect emergency contact and next of kin information from each new patient, and ask existing patients at least annually about any need to alter or update emergency information in their dental record; or any special instruction or restrictions they may elect (allowable by law) concerning the release of their personal health information to others.

While dentists are the owner of the dental patient records in their possession (physical or electronic), a patient generally has a legal right of access to the information contained in their own dental record or in that of a dependent family member. They may have a further legal right to restrict disclosures or release of the record. Consequently, dentists need to become familiar with state and federal requirements and formulate record release policies and procedures specific to their practice. A record release and disclosure policy in an emergency could allow access to the dental records by family members of missing or unidentified persons, or to law enforcement. Written procedures based on your policy should appear in your practice's office manual. Such procedures could help ensure necessary access or disclosure while simultaneously protecting dental record privacy.

In most cases, photocopies of written records are acceptable to a recipient unless originals are specifically required or authenticity is in dispute. If investigators agree to accept photocopies of written dental records, you should provide crisp, clear copies that include both sides of any document containing or providing information on two sides. If a single document contains multiple pages, consistently number and duplicate each page. Prior to releasing copies, make sure that each page identifies the individual in question and the dentist providing the record. If necessary, use a rubber stamp with the dentist's contact information on it, but do not obscure content on the page.

When releasing originals; inventory which documents you intend to release. Some dentists indicate a count on the front of the dental record of how many pages are included if the number is more than just a few. Recording the count could help investigators receiving the records know that they received every document in a large dental file.

Whenever possible, a dentist should release original records and radiographs in person, not by mail. It may also be a good idea for the dentist to obtain a receipt. Always retain a copy of the record.

## Subpoenas for Dental Records

A dentist with sufficient reason may chose to restrict (except to the patient) release or disclosure of some of the information contained in the dental records to authorized entities presenting a valid, properly served warrant, court order, subpoena or administrative request. Unless specifically directed, a dentist might chose, for example, to not disclose a summary in the record of a sensitive conversation that is unrelated to identification.

A dentist who gets a request to provide dental records in a forensic investigation should cooperate with authorities who properly identify themselves and who present the dentist with a valid, properly served warrant, court order, subpoena or administrative order. State laws and the HIPAA Privacy Rule, provide for the circumstances under which records may be released in the absence of a valid warrant or court order. Dentists may wish to consult with their private attorney in dealing with these situations.

Types of subpoenas:

- A “subpoena duces tecum” is an order for the dentist to appear in person with the required dental records. Check with your own attorney. In some states, a personal appearance may not be necessary.
- A “subpoena ad testificandum” is a written order demanding that a dentist appear and give testimony. This may be testimony at trial or a court hearing or by deposition. Again, consult with your attorney.

Before releasing any documents, original or copies, it is important to be certain to retain a duplicate set of any released documents. This will help the dentist to confirm the return of all records once the identification is made, and provide a record of what was produced while permitting the dentist at the same time, to maintain a file in the dentist’s possession.

If a requested record is “misfiled” or lost within your practice and cannot be located, the dentist should report the result of the unsuccessful search to requesting authorities as soon as possible.

Inactive dental records kept off-site or on microfiche may require more time to locate. However, a dentist responding to a valid subpoena may be required to produce the records by a date specified on the subpoena and within the time frame allowed by law. If the dentist is unable to comply with the subpoena or order within the specified time frame, he or she should immediately contact an attorney who may contact the requesting official to explain the situation.

A dentist who refuses to comply with a final, valid, properly served warrant, court order, subpoena or administrative request for records should appear in court to contest disclosure and explain the basis for refusing before any sanctions for failure to comply are imposed. Refusing to comply is very serious and not an ordinary option. You should not refuse to comply, for example, without first consulting your attorney for local court procedures because you do not want to be found in contempt of court.

## Releasing Dental Radiographs

If requested, a dentist should release the original radiographs of a patient to properly authorized investigators. Even a very old radiograph in good condition might assist investigators in identifying a victim in a forensic identification case.

Most duplicate or printed radiographs are not of diagnostic value and could delay victim identification. Radiographs include bitewings, occlusals, periapicals, panoramics and cephalometrics. If other radiographs of the head and neck of a patient are known to be held by a hospital or specialist, a dentist should give contact information so that investigators can reach these colleagues or institutions to collect additional information.

Denote “right” and “left” on mounted radiographs or how you read the indicator bubble. Indicate the date of exposure as well. For copied two-dimensional paper records there is no raised bubble to read, so labeling left and right could become critical whenever the paper copy is diagnostic.

Label any envelope containing radiographs with the patient’s name, unique patient identification and a count of the number of individual radiographs contained inside. To prevent loss of content seal each envelope containing loose radiographs before releasing them to authorities. Again, keep track of precisely which records are released.

Frequently, authorized investigators who are working to identify a body, the remains of a recovered missing person, or mass fatality victims may wish to clarify or confirm information with the dentist who released the victim’s radiographs. You should place your name, telephone number and address prominently on any radiographic envelopes or mounts that you release.

Another way to denote radiographs as from your office is by securely attaching your business card to each mounted radiograph or envelope. However, do not staple through any radiographs.

A suspected victim’s diagnostic casts, if they are available, can be used in identifications. Incidental information, such as rugae patterns on submitted casts, has been used to confirm an identification.

Your patient’s name and date of impression should appear on the casts. However, do not use pencil as pencil marks can come off or smudge during handling, possibly delaying a positive identification. Since diagnostic casts

are breakable, before release they should be securely wrapped to prevent damage in bubble wrap or loose packing material inside a case box with the dentist's contact information on the outside.

The American Dental Association's policy **Dental Radiographs for Victim Identification** (2003:363) gives guidance with regard to dentists making available original records to authorized investigators attempting to identify a disaster victim:

**Resolved**, that the ADA actively promote to practicing dentists the importance of providing, as permitted by state law, radiographs and original records of patients of record that are requested by a legally authorized entity for victim identification which will be returned to the dentist when no longer needed, and be it further

**Resolved**, that copies of these records should be retained by dentists as required by law.

ADA Policy **Dental Identification Efforts** (1985:588) encourages dental societies and others to assist in forensic investigations. The policy states:

**Resolved**, that the ADA encourage dental societies, related dental organizations and the membership to participate in efforts designed to assist in identifying missing and/or deceased individuals through dental records and other appropriate mechanisms.

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## Retention of Other Business Records

In addition to being familiar with the complexities of patient recordkeeping, as a small business a dental office also needs to retain other records.

Records maintenance is important to help with the following:

- Monitor the progress of your business
- Prepare financial statements
- Identify sources of revenue
- Keep track of deductible expenses
- Prepare tax returns
- Support items reported on your tax returns.

## Business Record Retention <sup>11,12,13,14,15</sup>

***Retention period is the number of years from the date of the tax return filed.***

***All information is general only and not offered as legal advice.\****

The proper retention period will vary from state to state and, maybe from practice to practice. Here is a typical schedule of retention periods. Yours may be different. Consult with an attorney to establish your own schedule.

Record Type	Retention Period
<b><i>Tax &amp; Financial Files**</i></b>	
Accounts payable ledger & schedule	7 yrs
Accounts receivable ledger & schedule	7 yrs
Audit/accountant annual report	Permanently
Bank statements (monthly)	3 yrs
Capital asset records	Permanently*
Cash receipt journal	Permanently*
Checks (cancelled – see exception below)	7 yrs
Checks (cancelled for important payment – i.e. taxes, purchases of property; file with transaction)	Permanently
Contracts and leases (expired)	7 yrs
Contracts, mortgages & leases (still in effect)	Permanently
Deeds, mortgages & bills of sale	Permanently
Deposit books & slips (duplicate)	3 or 6 yrs*
Depreciation schedules	Permanently
Financial statements (yearly)	Permanently
General ledgers	Permanently
Income tax returns, worksheets and related documentation	Permanently
Insurance policies (expired)	3 yrs
Insurance records, current accident reports, claims, policies, etc.	Permanently
Inventory of products, materials & supplies	7 yrs
List of accounts (assets, liabilities, revenue, expenses, etc)	Permanently
Petty cash vouchers	3 yrs
Retirement plan records (documents, investment records, allocations)	Permanently
Vouchers for payments to vendors, employees, etc. (includes allowances & reimbursement of employees, etc. for travel & entertainment expenses)	7 yrs
<b><i>Employment Records</i></b>	
Applications (not hired)	3 yrs
Personnel records (after termination)	7yrs
Payroll records, taxes & summaries	7 yrs
Time sheets, cards or time clock	7 yrs
Training manuals	Permanently
Workman compensation records	5 yrs
<b><i>Patient</i></b>	
Daysheets, schedule	7 yrs
Patient billing/payment or fee statements	7 yrs
Third-party insurance claims, records & correspondence (EOBs)	7 yrs
<b><i>Other**</i></b>	
Accident reports/claims (settled cases)	7 yrs
Controlled substance copy	2 yrs
Correspondence, routine with patients or vendors	2 yrs
Correspondence (legal or important)	Permanently
Legal agreements (partnership, associateship)	Permanently
Medicare billing records	7 yrs
OSHA records (log and summary)	5 yrs past the year to which it pertains

\*Check with your personal advisor, such as accountant, attorney or professional liability insurance company. State and federal laws may apply, in addition to the state dental practice act.

\*\*When your records are no longer needed for tax purposes, do not discard them until determining if you might need for a longer time period for other purposes. Fro example, your insurance company or creditors may require you to keep them longer than the IRS does.

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## Additional resources

To obtain the following resources, call the *ADA Catalog* at 1-800-947-4746 or order online at <http://www.adacatalog.org>. Following are just a few of the many titles available from the ADA Catalog Sales Department. You may order any of the publications by calling (800) 947-4746, or through the ADA's Web site at <http://www.adacatalog.org>.

*Fast-Track Training: The Basics for Dental Staff*. Chicago, Ill: Council on Dental Practice, American Dental Association; 2007.

*Basic Training II: for New Clinical Personnel*. Chicago, Ill; Council on Dental Practice, American Dental Association; 2002.

*Basic Training III: for Dental Administrative Personnel*. Chicago, Ill; Council on Dental Practice, American Dental Association; 2003.

*Employee Office Manual: A Guide for Dentists*. Chicago, Ill; Council on Dental Practice, American Dental Association; 2004.

*Frequently Asked Legal Questions: A Guide for Dentists and the Dental Team*. Chicago, Ill: Division of Legal Affairs, American Dental Association; 2004.

*HIPAA Privacy Kit*, American Dental Association; 2002.

*HIPAA Security Kit*, American Dental Association; 2005.

*Starting Your Dental Practice: A Complete Guide*. Chicago, Ill: Council on Dental Practice, American Dental Association, 2003.

*Valuing a Practice: A Guide for Dentists*. Chicago, Ill: Council on Dental Practice, American Dental Association; 2001.

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## Internet Resources

ADA Resources

<http://www.ada.org>

HIPAA <http://www.ada.org/goto/hipaa>

Risk management article database (members only)

Legal Adviser & law article database <http://www.ada.org/prof/prac/law/index.asp> (members only)

Emergency Planning & Disaster Recovery in the Dental Office  
[http://www.ada.org/prof/prac/planning\\_recovery\\_manual.pdf](http://www.ada.org/prof/prac/planning_recovery_manual.pdf)

Closing a Dental Practice <http://www.ada.org/prof/resources/topics/dentalpractice.asp#resources>

ADA Policy on **Identification Through Prosthetic Devices** (1978:181)  
[http://www.ada.org/prof/resources/positions/doc\\_policies.pdf](http://www.ada.org/prof/resources/positions/doc_policies.pdf) (page 117)

Legal & Ethical Frequently Asked Questions (FAQ)  
[http://www.ada.org/members/law/faq/patcare\\_confidentiality.asp](http://www.ada.org/members/law/faq/patcare_confidentiality.asp)

Directory of Professional Liability Insurers (members only)

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## Non ADA resources

The Dental Record <http://www.dentalrecord.com/>

Dealing with a Data Breach - Information Compromise and the Risk of Identity Theft: Guidance for Your Business, Federal Trade Commission, <http://www.ftc.gov/bcp/edu/microsites/idtheft/business/data-breach.html>.

American Records Management Association, <http://www.arma.org>

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## Business Records Resources Related Web Resources

Drug Enforcement Agency (DEA)  
<http://www.usdoj.gov/dea/pubs/csa/827.htm> - (21 USC Sec. 827 01/22/02)

IRS  
<http://www.irs.gov/publications/p583/index.html>

OSHA Record Keeping  
<http://www.osha.gov/recordkeeping/OSHArecordkeepingforms.pdf>

Small Business Administration  
<http://www.sba.gov>

BusinessTown – Accounting Basics  
<http://www.businesstown.com/accounting/basic.asp>

SBDCNet  
<http://sbdnet.org/SBIC/tax.php>

SCORE  
[http://www.score.org/template\\_gallery.html](http://www.score.org/template_gallery.html)

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## Forensic resources — Training

Armed Forces Institute of Pathology  
202-782-2100  
Washington, D.C.  
<http://www.afip.org>

University of Texas - Southwest Symposium on Forensic Dentistry  
Health Science Center  
San Antonio, TX  
210-567-3177  
<http://cde.uthscsa.edu/>

The Council on Dental Practice of the ADA sponsors training programs and conferences on basic dental forensic topics and techniques. Call the Council at 1-312-440-2895.

## Organizations

Disaster Mortuary Operational Response Team (DMORT)  
<http://www.dmort.org>

Professional Societies  
American Society of Forensic Odontology  
<http://www.asfo.org>

American Board of Forensic Odontology  
<http://www.abfo.org>  
The Diplomate's Manual produced by the ABFO is available at the site for free downloading.

American Academy of Forensic Science  
<http://www.aafs.org>

## References

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- <sup>1</sup> *Frequently Asked Legal Questions: A Guide for Dentists and the Dental Team*. Chicago, Ill: Division of Legal Affairs, American Dental Association; 2004.
- <sup>2</sup> Weber, R., J.D., Correcting and releasing dental records, *Journal of the Michigan Dental Association*, April/May 2000.
- <sup>3</sup> Pollack, Burton, R., *Law and Risk Management in Dental Practice*, New York, Quintessence Publishing Co, 2002.
- <sup>4</sup> ADA Principle of Ethics and Code of Professional Conduct.
- <sup>5</sup> American Medical Association, Patient Confidentiality, <http://www.ama-assn.org/ama/pub/category/print/4610.html>, accessed April 20, 2007.
- <sup>6</sup> Weber, Richard, Release of Dental Records, *Journal of the Michigan Dental Association*, (Vol. 83, No. 6), July/August, 2001.
- <sup>7</sup> *Frequently Asked Legal Questions: A Guide for Dentists and the Dental Team*. Chicago, Ill: Division of Legal Affairs, American Dental Association; 2004
- <sup>8</sup> *Closing a Dental Practice: A Guide for the Retiring Dentist or Surviving Spouse*, ADA, Council on Dental Practice, 2005.
- <sup>9</sup> *Frequently Asked Legal Questions: A Guide for Dentists and the Dental Team*. Chicago, Ill: Division of Legal Affairs, American Dental Association; 2004, p. 61-62.
- <sup>10</sup> *Valuing a Practice: A Guide for Dentists*, Council on Dental Practice, American Dental Association, 2006.
- <sup>11</sup> Publication 538 "Starting a business and keeping records," Internal Revenue Service, Jan 2007.
- <sup>12</sup> McGill, John, MBA, JD, CPA, How long should you keep your business records, *Journal of Clinical Orthodontics*, May 2003.
- <sup>13</sup> Paoloski, Susana, DDS, "When is it safe to pitch office papers," *Journal of the Greater Houston Dental Society*, Sept 2002.
- <sup>14</sup> Presavento & Pesavento, LTD, CPAs, "Records retention schedule," *Collier, Sarnier and Assoc Newsletter*, Berwyn, IL, May 15, 2005.
- <sup>15</sup> "Records retention schedule," Certified Public Accounts & Consultants, SalmonBeach & Associates, PLLC, <http://www.salmonbeach.com/pdfs/2007RecordsRetentionSchedul.pdf>, accessed June 8, 2007.

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## APPENDIX

### **GENERAL GUIDELINES FOR REFERRING DENTAL PATIENTS**

Revised June 2007

American Dental Association

Council on Dental Practice

At the direction of the Council on Dental Practice these *General Guidelines* have been designed as a discussion about appropriate procedures for referrals and are intended to promote an improved patient referral process. The information is necessarily general in scope and cannot cover every situation or detail. The information provided is not to be construed as legal advice or a legal standard, and cannot serve as a substitute for a dentist's own professional judgment or consultation with an attorney. These *General Guidelines* were developed by the Council on Dental Practice with input from many dental-related organizations and should not be interpreted as policy of the American Dental Association or any of its other agencies.

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## General Guidelines For Referring Dental Patients

### Introduction

Appropriate referrals are an integral part of complete quality health care management. Referrals should be based on the education, training, interest, and experience of the referring dentist and the unique needs of the patient. Dentists are expected to recognize the extent of the treatment needs of their patients and when referrals are necessary. These General Guidelines assume the dentist has the requisite skill and knowledge in diagnosis and treatment planning to determine when a referral is needed.

The term "referring dentist," when used in this document, usually means the primary dental care provider as defined by the ADA in *Trans.*1994:668. The referring dentist may be a specialist.\* In situations where two or more dentists are involved in the treatment of the patient, communication between all parties is essential. The referring dentist usually manages the overall dental health care of the patient, although there may be times when this role is assumed by another dentist.

The term "consulting dentist," when used in this document, usually means the dentist who is not the primary dental care provider.

Any care rendered by a consulting dentist should be coordinated with that of the referring dentist, and any other dentists involved in the treatment. Each dentist should have a clear understanding of the role each is playing in providing care to the patient.

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\*The American Dental Association officially recognizes nine specialty areas of dental practice: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics.

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The following citations related to referrals are found in the American Dental Association's ***Principles of Ethics and Code of Professional Conduct***:

Section 1.A. **PATIENT INVOLVEMENT**

The dentist should inform the patient of the proposed treatment, and any reasonable alternatives, in a manner that allows the patient to become involved in treatment decisions.

Section 2.B. **CONSULTATION AND REFERRAL**

Dentists shall be obliged to seek consultation, if possible, whenever the welfare of patients will be safeguarded or advanced by utilizing those who have special skills, knowledge, and experience. When patients visit or are referred to specialists or consulting dentists for consultation:

1. The specialists or consulting dentists upon completion of their care shall return the patient, unless the patient expressly reveals a different preference, to the referring dentist, or, if none, to the dentist of record for future care.
2. The specialists shall be obligated when there is no referring dentist and upon completion of their treatment to inform patients when there is a need for further dental care.

Advisory Opinion

2.B.1. **Second Opinions.** A dentist who has a patient referred by a third party\* for a "second opinion" regarding a diagnosis or treatment plan recommended by the patient's treating dentist should render the requested second opinion in accordance with this Code of Ethics. In the interest of the patient being afforded quality care, the dentist rendering the second opinion should not have a vested interest in the ensuing recommendation.

Section 4.B. **EMERGENCY SERVICE**

Dentists shall be obliged to make reasonable arrangements for the emergency care of their patients of record. Dentists shall be obliged when consulted in an emergency by patients not of record to make reasonable arrangements for emergency care. If treatment is provided, the dentist, upon completion of such treatment, is obligated to return the patient to his or her regular dentist unless the patient expressly reveals a different preference.

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\*A third party is any party to a dental prepayment contract that may collect premiums, assume financial risks, pay claims, and/or provide administrative services.

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## POSSIBLE REFERRAL SITUATIONS OR CONDITIONS

Patients may need to be referred for several reasons. Any one or combinations of the following situations or conditions may provide the dentist with an appropriate rationale for referring a patient. Some of these situations include, but are not limited to:

- ◆ Level of training and experience of the dentist
- ◆ Dentist's areas of interest
- ◆ Extensiveness of the problem
- ◆ Complexity of the treatment
- ◆ Medical complications
- ◆ Patient load
- ◆ Availability of special equipment and instruments
- ◆ Staff capabilities and training
- ◆ Patient desires
- ◆ Behavioral concerns
- ◆ Desire to share responsibility for patient care
  - ◆ Geographic proximity of the specialist or consulting dentist

## ELEMENTS OF DENTAL PATIENT REFERRALS

Communication from the Referring Dentist to the Specialist or Consulting Dentist: The referring dentist should convey appropriate information to the specialist or consulting dentist. While this information may vary on an individual patient basis, it could include, but is not limited to, the following:

- ◆ Name and address of the patient
- ◆ Scheduled appointment date and time with specialist or consulting dentist
- ◆ Reason for the referral/diagnosis
- ◆ General background information about the patient which may affect the referral
- ◆ Authorization or release of records
- ◆ Medical and dental information, which may include:
  - Medical consultations and specific problems
  - Contributory dental history
  - Diagnostic casts
  - Radiographic or digital images
- ◆ Future treatment needs beyond the referral
- ◆ Urgency of the situation, if an emergency
- ◆ Information already provided to patient

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Additional information may be found in the section on "Facilitating and Improving the Referral Process."

Communication from the Referring Dentist to the Patient: Many times the referral process is unfamiliar to dental patients who have become accustomed to receiving their routine care at one office. It is essential that all parties involved understand what is necessary to complete the referral successfully. The referring dentist may wish to consider the following points when communicating with the patient:

- ◆ An assessment of the patient's ability to understand and follow instructions
- ◆ An explanation of the reason for the recommended referral to the patient, patient's parent or legal guardian as appropriate
- ◆ An explanation of which area of dentistry or specialty is chosen and why
- ◆ If possible, making a specific appointment with the specialist or consulting dentist
- ◆ If known and if requested by the patient, providing information about the specialist or consulting dentist's fee for the consultation or evaluation
- ◆ Giving instructions that will assist the patient's introduction to the specialist or consulting dentist, i.e., preoperative instructions, educational pamphlets or a map with directions

Communication from the Specialist or Consulting Dentist to the Patient: The specialist or consulting dentist may wish to consider the following points when communicating with patient:

- ◆ Oral and/or written summary of the appointment
- ◆ Proposed additional and alternative treatment
- ◆ Details regarding the coordination of future treatment
- ◆ Follow-up appointments, if needed, and a return to the referring dentist for completion of other treatments and/or maintenance
- ◆ Consequences of no treatment
- ◆ Details of fees and payment options

Pre-Referral Communication Between Referring Dentist and Specialist or Consulting Dentist:

Both practitioners should discuss the referral treatment period and the return of the patient to the referring dentist. This arrangement may be enhanced by an exchange of business cards, referral forms and patient instructional materials. Availability for emergency treatment during the referral period should be discussed.

Post-Referral Communication Between the Specialist or Consulting Dentist and the Referring Dentist:

Communication between professionals is essential. Patients should receive clear, consistent information about their dental problems and treatment from all dental professionals. Mixed

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messages can confuse and frustrate patients. The following steps can facilitate the communication process:

- ◆ Initial report from specialist or consulting dentist indicating the preliminary diagnosis and anticipated treatment
- ◆ Progress reports as necessary, if treatment is extended over a considerable period of time
- ◆ Final report, including factors that may alter the future course of therapy or affect the relationship between the referring dentist and the patient.
- ◆ Diagnostic quality copies or duplicates of radiographic or digital images taken by specialist or consulting dentist
- ◆ Return of any pertinent documents or forms provided by the referring dentist

### **FACILITATING AND IMPROVING THE REFERRAL PROCESS**

Personal knowledge of the specialist or consulting dentist will allow patient needs to be met most appropriately. Inquiries about training and experience, including participation in continuing education and study clubs, may assist the referring dentist in determining where to refer particular dental patients. A visit to the office to observe treatment may be helpful.

Encouraging questions from patients about the referral and responding in lay terminology can ease some of the apprehension associated with unfamiliar treatments or providers. If language barriers exist, every effort should be made to ensure that the patient fully understands the reasons for the referral.

### **LEGAL AND ETHICAL ISSUES**

The focus of this publication is on sound dental practice options relative to patient referrals. The examples given may or may not be appropriate legally, depending on a variety of factors. Some of the legal and ethical considerations pertaining to referrals are noted below

#### Legal Considerations:

The law may bear on whether and how a referral may be made. One example about “whether” comes from the Supreme Court, which has guided that under the Americans with Disabilities Act, the refusal to treat a patient with HIV would require a scientific basis; a referral to a clinic with more experience treating persons with HIV or any disability cannot be based solely on the dentist’s personal level of comfort.

As for “how,” state law varies regarding communication with the doctor to whom the referral is being made. In some states communication from the referring doctor may be mandatory, in others it may be permitted, and in others patient consent may be required.

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The issue of consent, and the related but distinct issue of authorization as required by HIPAA, open a wide array of questions pertaining to confidentiality, privacy and security. While these issues are beyond the scope of this publication, it is important to know what laws apply to you, and that you secure any and all permissions required. Keep in mind HIPAA covers only certain dental offices – are you a covered entity? -- and state law varies.

Dentists should recognize that separate and possibly conflicting legal interests may be involved during a referral. Particular attention should be directed toward patients or providers whose interests and requirements are detailed in contract form. When dentists or patients participate in such arrangements related to dental services, these arrangements should be reviewed carefully with respect to restrictions that may be placed on the dentist's ability to refer patients to other settings or other dentists for care.

**Note:** In some situations, a dentist could be held legally responsible for treatment performed by specialist or consulting dentists. Therefore, referring dentists should independently assess the qualifications of participating specialist or consulting dentists as it relates to specific patient needs. The dentist is reminded that contract obligations do not alter the standard of care owed to all patients.

**Ethical Considerations:** In addition to the ethical provisions reflected on page 3, dentists have an ethical obligation to discuss their referral information with the patient in an appropriate manner. The **ADA Principles of Ethics and Code of Professional Conduct** contains the following:

#### Section 4.C. JUSTIFIABLE CRITICISM

Dentists shall be obliged to report to the appropriate reviewing agency as determined by the local component or constituent society instances of gross or continual faulty treatment by other dentists. Patients should be informed of their present oral health status without disparaging comment about prior services. Dentists issuing a public statement with respect to the profession shall have a reasonable basis to believe that the comments made are true.

#### Advisory Opinion

4.C.1. Meaning of "Justifiable." Patients are dependent on the expertise of dentists to know their oral health status. Therefore, when informing a patient of the status of his or her oral health, the dentist should exercise care that the comments made are truthful, informed and justifiable. This may involve consultation with the previous treating dentist(s), in accordance with applicable law, to determine under what circumstances and conditions the treatment was performed. A difference of opinion as to preferred treatment should not be communicated to the patient in a manner which would unjustly imply mistreatment. There will necessarily be cases where it will be difficult to determine whether the comments made are justifiable. Therefore, this section is phrased to address the discretion of dentists and advises against unknowing or unjustifiable disparaging statements against another dentist. However, it should be noted that, where comments are made which are not supportable and therefore unjustified, such comments can be the basis for the institution of a disciplinary proceeding against the dentist making such statements.

#### Reading List:

**ADA Principles of Ethics and Code of Professional Conduct**, Council on Ethics, Bylaws and Judicial Affairs, American Dental Association, see <http://www.ada.org>.