Dentist Referral Agreement

[MHS Mobile Dental]

Office Address: 13046 Kayleigh Cove, Biloxi, MS 39532
Mailing Address: P.O. Box 12605, Jackson, MS 39236
Website: www.mhsmobiledental.com * **Email:** mhsmobiledental@gmail.com
Office: 844-737-7331 * **Fax:** 877-737-7331

This agreement is signed by and agreed upon by the parties listed below:

A) MHS Mobile Dental

B) _____ (The Referral Dentist or Clinic)

_____ (address) _____ (phone)

MHS Mobile Dental is authorized through MSBDE regulation 61 to provide oral health care including but not limited to dental screenings/exams, cleaning, fluoride treatment, and sealant, and the Referral Dentist is authorized to provide other general oral health/dental services. MHS has determined that the students/patients that it serves may require these other services provided by the Referral Dentist.

Regarding services rendered by the Referral Dentist to students participating in the MHS Mobile Dental outreach program, it is agreed that:
Students participating in this program who are assessed with acute oral disease will be referred to the Referral Dentist who has agreed to see the students and treat the acute oral disease in their office in the usual way in which patients are accommodated for oral health emergencies.

It is not expected that the Referral Dentist will change their normal practice policies or patterns to accommodate these referral patients, but rather it is agreed that they will treat these referrals in the same way they normally treat patients in need of emergency treatment.

It is not expected that the Referral Dentist will in any way upset the normal day-to-day operations of their practice to treat these referrals. The Referral Dentist is not expected to change clinic payment policy in regards to the referral patients from the MHS Mobile Dental school-based program. It is also not expected that these students will become regular patients of the Referral Dentist's practice unless the Referral Dentist is currently accepting new patients.

_____ _____
MHS Mobile Dental Representative **Date**

_____ _____
Referral Dentist or Clinic Representative **Date**

MHS Mobile Dental