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MISSOURI DENTAL BOARD

**SETTLEMENT AGREEMENT BETWEEN MISSOURI DENTAL BOARD
AND STANLEY S. SCOTT, D.D.S.**

Come now Stanley S. Scott, D.D.S., ("Licensee") and the Missouri Dental Board ("Board") and enter into this settlement agreement for the purpose of resolving the question of whether Licensee's license as a dentist will be subject to discipline.

Pursuant to the terms of § 536.060, RSMo 2000¹, the parties hereto waive the right to a hearing by the Administrative Hearing Commission of the State of Missouri ("AHC") regarding cause to discipline the Licensee's license, and, additionally, the right to a disciplinary hearing before the Board under § 621.110, RSMo 2000.

Licensee acknowledges that he understands the various rights and privileges afforded him by law, including the right to a hearing of the charges against him; the right to appear and be represented by legal counsel; the right to have all charges against him proven upon the record by competent and substantial evidence; the right to cross-examine any witnesses appearing at the hearing against him; the right to present evidence on his own behalf at the hearing; the right to a decision upon the record by a fair and impartial administrative hearing commissioner concerning the charges pending against him and, subsequently, the right to a disciplinary hearing before the Board at which time he may present evidence in mitigation of discipline; and the right to recover attorney's fees incurred in defending this action against his license. Being aware of these rights provided him by operation of law, Licensee knowingly and voluntarily waives each and every one of these rights and freely enters into this settlement agreement and agrees to abide by the terms of this document, as they pertain to him.

Licensee acknowledges that he has received a copy of the investigative report and other documents relied upon by the Board in determining there was cause to discipline his license, along with citations to law and/or regulations the Board believes was violated.

For the purpose of settling this dispute, Licensee stipulates that the factual allegations contained in this settlement agreement are true and stipulates with the Board that Licensee's license, numbered 012620 is subject to disciplinary action by the Board in accordance with the provisions of Chapters 621 and 332, RSMo

¹ All statutory references are to Missouri Revised Statutes 2000, as amended, unless otherwise indicated.



Joint Stipulation of Fact and Conclusions of Law

1. The Missouri Dental Board ("Board") is an agency of the State of Missouri created and established pursuant to § 332.021, RSMo, for the purpose of executing and enforcing the provisions of Chapter 332.
2. Licensee Stanley S. Scott, D.D.S. is licensed by the Board as a dentist, License No. 012620. Licensee's Missouri license is current and active.
3. On or about October 8, 2010, the Board received a complaint against Licensee from I.H., an employee of Licensee. I.H. alleged unprofessional conduct by Licensee. Her complaint stated that on one occasion when she took a drink of water from her water bottle, Licensee stated "Oh I., suck it." She stated that it made her feel very uncomfortable and disrespected. As a result of the complaint, the Board conducted an investigation of the complaint.
4. As part of the Board's investigation, on May 19, 2011, Board Investigator Kevin Davidson visited Licensee at his dental practice in Kansas City, Missouri. Upon arrival, Licensee stated that he had been a licensed dentist for 34 years and had been in the same practice location for 24 years. He stated he had two employees, I.H., who worked the front desk, and a dental assistant, Y.E. Licensee reviewed I.H.'s complaint in the presence of Investigator Davidson. Licensee stated that he did not recall the incident, did not make a habit of saying things like that, and was surprised I.H. made the complaint and had not said anything about it to him. He stated she had been a bit "standoffish." He stated he did not mean the remark in an offensive way. He stated I.H. had worked for him for three years and she had never told him he had made her uncomfortable.
5. As part of the Board's investigation, on May 19, 2011, Investigator Davidson met with Y.E. at Licensee's practice location. Y.E. stated that she had worked for Licensee for eleven years. She stated she was a dental assistant. Investigator Davidson asked Y.E. if she was aware of Licensee making inappropriate comments. Y.E. hesitated and then stated that Licensee jokes around a lot. Y.E. then whispered that he was sitting outside the operatory listening to what she was saying. She whispered that the wrong person could be offended by what Licensee says. She also stated that he had made inappropriate comments to her but she would not elaborate. She stated he was not the best to work for. She was very nervous. She stated that she needed to take care of the patient that had come into the lobby. Investigator Davidson provided her his business card.



6. As part of the Board's investigation, on May 19, 2011, Investigator Davidson met with I.H. at Licensee's practice location. She stated that she had worked for Licensee for four years and nine months. She stated she worked the front desk, filed insurance claims and did some chair side assisting. With regard to the incident for which she filed the complaint, she stated that she had taken a drink from her water bottle, Licensee saw her and said "Oooo I. suck it." I.H. stated she was shocked and the longer she thought about it, the more upset she got. She stated she got mad because she knew it was not right for him to say that. She said she filled out the complaint form and sent it into the Board. I.H. stated he had not made any additional remarks and she was not sure if he had made remarks to Y.E. But, I.H. stated that Y.E. told her he had said things to her that she found to be harassing and she looked uncomfortable when they discussed it. Investigator Davidson also left his business card with I.H.

7. At the initial visit, while in Licensee's practice, Investigator Davidson observed a water fountain with dental castings in the basin of the fountain. He observed that the sterilization area was adjacent to the lunch area. There were dental utensils lying on the counter and only a couple of the utensils were bagged as required for sterilization. Investigator Davidson asked I.H. who in the office conducted spore testing. I.H. replied, "What testing?" She stated she had never witnessed any testing on the sterilization equipment since she started working there.

8. On May 26, 2011, Investigator Davidson received a telephone call from Y.E. She stated that when they spoke the first time, she could not really say anything because Licensee was listening. She stated that she could not afford to quit her job and so she "put up with the situation." She stated that Licensee made lewd comments all the time and was very "touchy." She stated he would touch her on the arm or put his arm around her and claim it was an accident. She stated recently, she bent over to pick something up and when she stood up, he was behind her and kissed her on the back of the neck. She stated she walked away from him. She stated that Licensee makes comments to patients as well. She stated he asked a female patient if she was married and if she said no, he would say, "Do you want to be?" She stated if a female patient has tattoos, he comments on them, asks if there are any others that are not visible and asks to go in the back room to see all of them. She stated that there are "cleanliness" issues in the office. She stated that in the past, she would sterilize the burs and he told her not to do so because it would make them dull. She stated he carries them around in a pouch in his pocket. She stated Licensee tells her to "just wipe things down with alcohol and that's good



enough." She stated that Licensee does not change his gloves between patients and that he walks around the office with them on, touching whatever, and then goes to the next patient. She stated that on one occasion, she tried to give him a new pair for a new patient and he waved her off and kept working on the patient. She stated that between patients, she has tried to wipe down the chairs but Licensee told her not to because they did not have time to do so. She stated that Licensee does not buy many supplies for the office. She stated she guessed the average number of patients they saw in a day was twelve but it varied from one to 50. She stated she tried to discuss the infection control issues with Licensee several times. She stated he told her he had run the business before she came and he could run it after she was gone. She stated that at times, when she was getting ready to take x-rays of an older person, Licensee would tell her not to use the lead apron because the person was not going to have kids anymore. She stated he does use it on children. She stated the patient record system was "terrible." She stated that when x-rays are taken they are not always labeled with the patient's name right away. Sometimes they are put in a box and left in the back room. She stated there are boxes and boxes of them, some undeveloped. She stated that when Medicaid has conducted an audit, she has seen Licensee get an unlabeled x-ray from the box and write the person's name on it and put it in the file so that it appears that all the information is in the file. She stated he did that for Family Health Providers who dropped Licensee as a provider.

9. On August 4, 2011, Investigator Davidson returned to Licensee's office to complete an infection control inspection. As Investigator Davidson and Licensee walked into Licensee's office, Licensee stated that he had been thinking about the complaint I.H. made against him. He stated he remembered that she was drinking something from a cup from a straw and she was really sucking on the straw hard. He stated she was making a gulping sound and he made a comment about how she was really sucking hard on that drink. He stated he did not realize she had taken offense to the comment. Investigator Davidson then completed the Infection Control Inspection and Report. He marked two areas that were noncompliant: question five: Is the sterilization equipment properly tested to verify whether they are functioning properly; and question ten: Proper disposal/handling of potentially hazardous/infective waste. Regarding question number five, Licensee stated that they did not test the autoclave equipment. He stated they had recently purchased the autoclave used and had not tested it. He stated they purchased the autoclave about a year ago. Investigator Davidson informed him that according to Centers for Disease Control (CDC) standards, it had to be tested weekly with logs of the



tests maintained for inspection. Investigator Davidson also informed Licensee that he needed to begin that immediately and fax the results to the Board office and continue to do so until further notice. Regarding question number ten, Investigator Davidson did not observe any hazardous waste bags or Sharps containers in the office. He asked Licensee what they did with their infectious waste. Licensee stated it was "wrapped up and put into the trash." Investigator Davidson informed him that per CDC guidelines, that was not acceptable and must be changed immediately. Licensee stated he would take care of it. Licensee stated that I.H. typically cleaned the operatories between patients. I.H. demonstrated what she did to clean between patients. Investigator Davidson noticed that the trash cans were over half full. I.H. stated they emptied the trash nightly but Licensee would not allow them to change the trash bags, just dump the trash into a bigger bag to put into the dumpster.

10. On August 26, 2011, Investigator Davidson received a telephone call from I.H. I.H. stated that she believed that Licensee was committing Medicaid fraud. She stated that he sees lots of children under the Medicaid program. She stated the children are eligible for an exam and cleaning once every six months and one day. She stated that sometimes the children come in before the six months and Licensee goes ahead and treats them and then holds onto the billing until they are past six months and one day and then bills for the services to Doral or DentaQuest. She stated that personnel from Doral came into the office to audit the records and stated that Doral considered that fraud. I.H. stated that Licensee does not chart much for the Medicaid patients. She stated he only charts for insurance or cash patients. On August 29, 2011, I.H. called again to report that Licensee terminated her.

11. On September 8, 2011, Investigator Davidson returned to Licensee's office to follow up on Licensee's infection control procedures, including testing of his autoclave. Licensee stated that he had been testing the autoclave every Thursday afternoon and had faxed the results to the Board office. He stated he was not maintaining a test log but would start. Investigator Davidson noted that the overall appearance of the practice had improved since the first visit. He stated that due to economic hardship, he had let I.H. go and that business had slowed down considerably.

12. On September 2 and October 4, 2011, Licensee faxed test results from Biological Monitoring Systems, inc. to the Board. There were a total of seven spore tests completed for Licensee's sterilization equipment. The result for all of the tests was "passed."



13. On November 8, 2011, Investigator Davidson submitted letters to Blue Cross Blue Shield of Kansas City and Molina Health Care requesting claims data submitted by Licensee.

14. On November 22, 2011, DentaQuest submitted documentation on behalf of Blue Cross Blue Shield. The documentation included a letter from Ann Conrad, UR/Fraud & Abuse Specialist, the company's Referral to Provider Quality Assurance Committee, which included the reason for the audit of Licensee's practice, synopsis of audit and findings, a 2010 audit, the expanded audit in 2011, and a CD containing claims history for Licensee.

15. The documentation from DentaQuest stated that the reasons for the audit were that multiple employees alleged that Licensee was billing for treatment he did not render, changing the dates of services for payment when there were benefit limitations, and that he was billing for services prior to the member being seen. DentaQuest performed the audit to confirm treatment was billed as paid by the reviewing documentation. It also performed a second expanded audit at the request of the health plans, Dental Director and Peer Review Committee. DentaQuest audit and phone conversation with Licensee confirmed that Licensee does not maintain a paper or electronic record that can be reproduced. Licensee submitted reproduced handwritten records for review based on his computer ledger. DentaQuest's Peer Review Committee requested termination of Licensee as a provider with no recovery of billed and paid services. The audit also found that Licensee recouped inappropriately billed services and received education about billing. However, a reaudit was done and Licensee was using a billing code inappropriately. A third audit revealed that Licensee billed for service prior to treatment, billed for services not rendered, and changed the dates of service to qualify for payment. Licensee was not able to provide a written record to DentaQuest. He reproduced the records he provided by copying them off his computer ledger as he cannot print from it. He had no signed consent forms, no copies of ID cards, and no updated health history for patients. DentaQuest also determined that Licensee submitted radiograph and written documentation that supported the failure to diagnose and/or treatment plan decay. Licensee billed for specific codes when there was no medical necessity and bundled his x-rays and billed for them when they are not supported in the records. His patients had no current medical history and some were five or six years old. He stated he had never used patient consent forms and did not intend to start. Licensee billed for teeth but had no documentation of the tooth number or surface. DentaQuest ultimately terminated Licensee as a provider as a result of the audit determinations.



16. On November 29, 2011, the Board received documentation from Molina Healthcare of Missouri including a letter from Elizabeth A. Scott, Compliance Director, an audit for patient K.T., and claims history submitted by Dr. Scott. Molina Healthcare reviewed the DentaQuest audit for claims between July 1, 2010 and June 30, 2011. Molina Healthcare also determined that Licensee frequently billed for services not supported in the treatment record of the patient.

17. On January 4, 2012, Investigator Davidson returned to Licensee's office for a follow-up infection control inspection. While there, Investigator Davidson observed Licensee treating a patient in one of his operatories and when he came out to meet Investigator Davidson, Licensee was still wearing his rubber gloves. He had a face mask on but it was pulled down below his mouth. After speaking with Investigator Davidson briefly, Licensee returned to the patient in the operatory but did not change his gloves or mask. Investigator Davidson completed the Infection Control Report and again found that Licensee was lacking in the area of sterilization equipment testing. Investigator Davidson asked Licensee for sterilization records. Licensee stated that the autoclave he was using "was a loaner" because his autoclave malfunctioned and he had to send it in for repair. Investigator Davidson asked him if he had been testing the "loner" and Licensee stated that he had not. Investigator Davidson informed him that he needed to test it if it was being used regularly to make sure it functioned properly. He also informed Licensee that he needed to continue sending the monthly reports of the testing results which the Board had not received since October 8, 2011. Investigator Davidson also addressed the issue with Licensee's glove and mask usage and told Licensee that whenever he left an operatory, he needed to dispose of the gloves and mask he was wearing and put on new ones when he returned.

18. Licensee appeared before the Board on April 19, 2012 at 9:00 a.m. During the appearance, Licensee stated that "he does not tell off-colored jokes." He stated with regard to the complaint from I.H., there were no patients in the office at the time. He stated he was headed toward the front of the office and heard someone sucking on a straw loudly. He stated that I.H. was sucking on a large straw out of a big cup and she was getting near the end of the cup. He says he stated loudly over the noise, "You're really sucking on that I." He stated there was no hidden meaning or sexual innuendo and that he did not know it bothered her until Investigator Davidson's visit. Licensee stated that he had two full time, including I.H. and Y.E., and two part-time employees. With regard to patient medical histories, Licensee stated that they "don't update it as often as we should. We update it annually, sometimes it's every two years." Licensee stated that he asks the patients if



there has been a change in their history but it is not always documented in the chart. Licensee stated he stopped seeing Medicaid patients in February 2012 because he was terminated from DentaQuest "for no cause." He stated that both he and the staff complete charts and insurance forms but the staff does a lot of the writing in charts. Licensee stated he does not have consent forms for the parents of the children he treats. Licensee stated he does not have a HIPAA compliance forms for patients sign before treatment. He stated he does not keep copies of the patients' insurance cards, IDs or Medicaid cards. He stated the office writes the patients number in the chart. Licensee explained the type of x-rays he orders for patients and stated that the patient always has a lead apron over them during the x-ray, no matter the patient's age. Licensee does not have protection for staff when they take the x-ray but stated they were "so far away, that's not necessary, I don't think." He stated that the state came and checked the x-ray machine every three or four years but he had no documentation of that. He stated that "they send me a letter saying everything was fine and it goes in the trash when I get it." Licensee stated that all the staff in the office wears masks for infection control and gloves. He stated the staff has on protective covering but he does not. He stated he does not wear anything to protect himself, just his street clothes, usually with a long sleeve shirt. He stated the assistants have scrubs and jackets that get laundered. He stated "it looks like they change them daily." With regard to sterilizing instruments, Licensee stated they have a cold sterilizer in which they put all the instruments after they wash them with water and "scrub them." Then they got in a heat sterilizer, but not an ultrasonic sterilizer. Licensee stated that the surgical instruments were bagged before being put in the sterilizer, the hand instruments are not. Licensee stated that they all take out the trash. He stated they put all the trash in a large dumpster out back. If there are blood-soaked gauze and gloves, they are placed in the trash and then into the dumpster. Licensee stated he did not have red biohazard bags for the potentially infectious waste. He stated the sharps syringes are put in "a couple of plastic containers" with the needle bent. He stated he had not gotten rid of the plastic containers: "They're all in a big bag right now and they just [have] not been disposed. I have big plastic bags and I have not disposed of them as of yet." He stated he hadn't decided how he was going to dispose of them yet. He stated he was not audited by Medicaid but was terminated without cause. The records Licensee did provide, which the Board evaluated, were not from the patients' records. Licensee "wrote them down from the computer system." Licensee stated that he might not document each visit in the patient's chart, just the first visit. Licensee stated that he does use x-rays to diagnose patients. He stated that "many times we don't develop the x-rays.



Sometimes we don't develop the x-rays until after the patients leave and so we don't have a chance to go back and take new x-rays." Licensee stated that "Many times we don't have the opportunity "to develop the x-rays while the patient is there" because we're so busy we can't get to develop them. We write names on the picture and they get developed later. Many times we're too busy, don't have enough staff to do that at that time. So it's not always possible." He also stated that he could not attest to the x-rays he had with a patient file actually being that patient's x-rays. He stated "if you come to my office, you would see there is some chaotic situation in there. We have done tons of x-rays that still have not been developed and the x-rays could have been – could have been transposed and this might not actually be the young child's x-ray." He stated he "still [has] a big box of x-rays that still have not been developed." Licensee was not able to say for how long he had x-rays in the big box of x-rays. He stated that "I'm guilty in that many times we do not develop the x-rays on the timely manner and hopefully we will see the patient back before they have a major problem." Licensee stated that he bills for the x-ray right away "in that we did take the picture" even if it does not get developed. He stated he's billing for the fact that they took the picture. Licensee stated that if he is taking the x-ray and billing for it, he has a legal responsibility to read it. Licensee admitted that by the time it got developed a year later, it might no longer be of diagnostic value. He stated he had never thought of that before the discussion with the Board. Licensee stated he always intends to develop and read it, he just gets "backed up, [] doesn't get to it and it gets put off." Licensee stated he did not believe that was a reasonable standard of care for a dentist. Licensee stated that he does have written patient charts but that he "can't always find them[.] And it's a hassle trying to find them." Licensee stated that the records provided for the Medicaid audit were his handwritten records while looking at the computer screen from his daily log on the computer. Licensee did not inform Medicaid or the Board, until the meeting, that they were not true patient records. He stated that he agreed with the Board that he had some significant system problems at the office. He stated that the billing he did for services provided was "totally accurate." He stated if he had to prove that to the Board he would look at the data log in the computer and that he was "quite sure we billed for those services. I can't vouch for --." He stated some of the patient records would be hard to find. He stated with medical history, "we'd probably do it every year, a couple years, something like that." He stated that he does not have a set protocol for updating patient health history. He stated an updated history had "updated" stamped on it but none of the records the Board reviewed for patients had the "updated" stamp. Licensee agreed with the Board that his office was in chaos based on all the



violations discussed by the Board during the meeting. Licensee stated that he had several years worth of Sharps, probably five years worth. He stated that the bags for the other years of the 37 he had been in practice were in bags in his basement at his home. He stated he did "throw out some of them" in the dumpster before he knew he was not supposed to do that. He stated he did double bag it to try and avoid someone being injured. He stated that it had been "some years" since anyone in his office had taken an OSHA course regarding infection control. Licensee stated he did not believe he had met the documentation requirements contained in § 332.052, RSMo. He stated that he threw out some records that were over ten years old but that he "probably" had records for the last ten years on patients. Licensee corrected himself and stated he had not thrown them out but that there were in a big box in his basement. He stated he had the records that "are over 30 years old and I haven't destroyed them so I haven't thought about how I would destroy them. I have it. They're still in boxes."

19. Section 191.694, RSMo states:

1. All health care professionals and health care facilities shall adhere to universal precautions, as defined by the Centers for Disease Control of the United States Public Health Service, including the appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments, to minimize the risk of transmission of HIV, HBV and other blood-borne infections to patients. Health care professionals and health care facilities shall comply with current guidelines, established by the Centers for Disease Control, for disinfection and sterilization of reusable devices used in invasive procedures.
2. Health care professionals who have exudative lesions or weeping dermatitis of the hands, forearms, or other locations that may contact patients, particularly on exposed areas such as hands or forearms, shall refrain from performing all invasive procedures, and from handling patient-care equipment and devices used in performing invasive procedures until the condition resolves.
3. As a condition for renewal of a certificate of registration or authority, permit, or license, all health care facilities shall provide satisfactory evidence that periodic training in infection control procedures, including universal precautions, is provided to all personnel who perform patient care services at or from such facilities. Regulations for such training shall be promulgated by the state regulatory authorities or bodies responsible for licensing the respective health care facilities.
4. All health care professionals who perform invasive procedures shall receive training on infection control procedures relevant to HIV and related diseases, including universal precautions and prevention of percutaneous injuries, appropriate for their specialty and approved by the department of health and senior services. The department of health and



senior services, in cooperation with appropriate state regulatory authorities responsible for licensing the respective health care professionals and in cooperation with professional societies, shall develop regulations for such training. The requirements set forth in this subsection shall be deemed satisfied if the health care professional completes the training provided in accordance with the provisions of subsection 3 of this section.

20. Section 332.052, RSMo states:

1. Dentists shall maintain an adequate and complete patient record for each patient and may maintain electronic records provided the record-keeping format is capable of being printed for review by the board.

2. Patient records remaining under the care, custody and control of the licensees shall be maintained by the licensee, or the licensee's designee, for a minimum of seven years from the date of when the last professional service was provided or in the case of a minor, seven years from the age of majority.

3. Any correction, addition, or change in any patient record made more than forty-eight hours after the final entry is entered in the record as an addendum shall be clearly marked and identified as such, and the date, time, and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition, or change.

4. Dentists and nondentists shall maintain copies of laboratory work orders for seven years.

21. Licensee's actions as described in paragraphs 4 through 18 above constitute incompetency, misconduct, and gross negligence in the functions and duties of a licensed dentist for which the Board has cause to discipline Licensee's license.

22. Licensee's actions as described in paragraphs 4 through 18 above constitute violation of a provision of this chapter or lawful rule or regulation adopted pursuant to this chapter, as described in paragraphs 19 and 20 above, for which the Board has cause to discipline Licensee's license.

23. Licensee's actions as described in paragraphs 4 through 18 above constitute violation of a professional trust or confidence for which the Board has cause to discipline Licensee's license.

24. Licensee's actions as described in paragraphs 4 through 18 above constitute the failure to properly guard against contagious, infectious or communicable diseases or the spread thereof for which the Board has cause to discipline Licensee's license.



25. Cause exists for the Board to take disciplinary action against Licensee's license under § 332.321.2(5), (6), (13), and (16) , RSMo, which states in pertinent part:

2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any permit or license required by this chapter or any person who has failed to renew or has surrendered his or her permit or license for any one or any combination of the following causes:

...

(5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by this chapter;

(6) Violation of, or assisting or enabling any person to violate, any provision of this chapter, or any lawful rule or regulation adopted pursuant to this chapter;

...

(13) Violation of any professional trust or confidence;

...

(16) Failure or refusal to properly guard against contagious, infectious or communicable diseases or the spread thereof[.]

Joint Agreed Disciplinary Order

26. Based upon the foregoing, the parties mutually agree and stipulate that the following shall constitute the disciplinary order entered by the Board in this matter under the authority of § 621.045.3, RSMo 2000: The terms of discipline shall include that the dental license, license number 012620, be **VOLUNTARILY SURRENDERED**, which shall be reportable as discipline against Licensee's license.

27. The parties to this Agreement understand that the Missouri Dental Board will maintain this Agreement as an open record of the Board as provided in Chapters 332, 610, and 324, RSMo.

28. The terms of this settlement agreement are contractual, legally enforceable, and binding, not merely recital. Except as otherwise provided herein, neither this settlement agreement nor any of its provisions may be changed, waived, discharged, or terminated, except by an instrument in writing signed by the party against whom the enforcement of the change, waiver, discharge, or termination is sought.



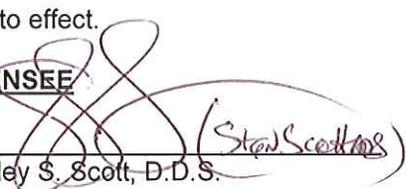
29. Licensee, together with his heirs and assigns, and his attorneys, do hereby waive, release, acquit and forever discharge the Board, its respective members and any of its employees, agents, or attorneys, including any former Board members, employees, agents, and attorneys, of, or from, any liability, claim, actions, causes of action, fees, costs and expenses, and compensation, including but not limited to, any claims for attorney's fees and expenses, including any claims pursuant to § 536.087, RSMo, or any claim arising under 42 U.S.C. § 1983, which may be based upon, arise out of, or relate to any of the matters raised in this case, its settlement, or from the negotiation or execution of this settlement agreement. The parties acknowledge that this paragraph is severable from the remaining portions of this settlement agreement in that it survives in perpetuity even in the event that any court of law deems this settlement agreement or any portion thereof to be void or unenforceable.

30. If no contested case has been filed against Licensee, Licensee has the right, either at the time the settlement agreement is signed by all parties or within fifteen days thereafter, to submit the agreement to the Administrative Hearing Commission for determination that the facts agreed to by the parties to the settlement agreement constitute grounds for denying or disciplining the license of the licensee. If Licensee desires the Administrative Hearing Commission to review this Agreement, Licensee may submit this request to:

Administrative Hearing Commission, Truman State Office Building, Room 640, 301 W. High Street, P.O. Box 1557, Jefferson City, Missouri 65101.

31. If Licensee has requested review, Licensee and Board jointly request that the Administrative Hearing Commission determine whether the facts set forth herein are grounds for disciplining Licensee's license and issue findings of fact and conclusions of law stating that the facts agreed to by the parties are grounds for disciplining Licensee's license. Effective the date the Administrative Hearing Commission determines that the agreement sets forth cause for disciplining Licensee's license, the agreed upon discipline set forth herein shall go into effect.

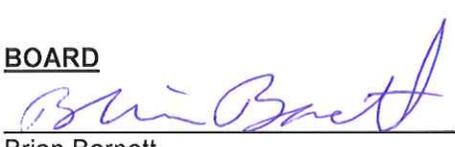
LICENSEE


Stanley S. Scott, D.D.S.

Date

8-13-2012

BOARD


Brian Barnett,
Executive Director
Missouri Dental Board

Date

8/16/12

