General Consent for Dental Treatment

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I understand the purpose of this general consent is to raise my awareness of risks that are common- place in many dental procedures. I understand my dentist reserves the right where appropriate to provide me with a more specific informed consent discussion (for example: for root canal therapy, extractions, treatment of gum disease and placement and restoration of implants).

I understand that every dental patient has the right to informed consent. That means that as a patient, or as a legal guardian for a patient I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment. Of course, one alternative for me is to do nothing, although that carries with it its own risk.

My signature below confirms that I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

I understand that some after-treatment effects and complications tend to occur with regularity.

For routine dental cleanings, fillings, crown and bridge procedures, and prescriptions of medications, I understand this includes but is not limited to: temporary soreness, temperature sensitivity, unusual reaction/ allergy to medications given or prescribed. Also, medications have common side effects that are listed by the manufacturer. Further, if I am taking other medications, my dental medications could have an adverse interaction, and I need to fully disclose all of my medications to the dentist and pharmacist. This includes herbal supplements.

For the administration of local anesthetic, I understand that for many treatments and procedures I will be given a local anesthetic injection and that in a certain percentage of cases patients have had an allergic reaction to the anesthetic, or temporary and/ or permanent injury to nerves and/ or blood vessels from the injection. For oral surgery, I understand that there is always a risk of a post operative infection, nerve damage, and iatrogenic injury. I understand the injection area(s) may be uncomfortable after treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I understand that all treatments and procedures have a risk of separation of dental instruments which may become lodged in a gum or other soft tissue or aspirated. Should I experience any of these or other conditions during or following treatment, I will contact this office as soon as possible.

I understand that the practice of dentistry is not an exact science and my dentist offers no guarantees or assurance as to the outcome or results of treatment or surgery.

I have the right to ask my dentist for more information if I have any concerns about my procedures and the possible side effects or complications. I promise to use that right to its fullest intent if for any reason I feel that I am not fully informed about my procedure, the risk of the procedures, and my alternative to the procedure.

Patient Name Patient/Guardian Signature Date

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosure of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Patient Name **Patient/Guardian Signature** **Date**

If there is any other person who we can discuss your PHI with, please list here and sign for consent.

Print Name **Relationship to Patient** **Patient Signature**

GENERAL CONSENT FOR RADIOGRAPHS

Please initial below to consent for radiographs (x-rays) or not.

- **I understand that the Doctor, the Hygienist, or the Dental Assistant may need to take x-rays of my teeth for proper diagnosis and treatment planning.**

  Initials: _____
- **It is my right to not consent to these x-rays. I understand that by not consenting to x-rays, the doctor will not be responsible for any missed diagnosis of dental of periodontal pathology.**

  Initials: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of the Personal Health Information (PHI) has been identified as a national problem causing patients to inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.