John B. Dale, D.M.D., M.S., P.C.

Consent for Treatment

Patient's Name: _____ Date: _____

1. Endodontics, as with any branch of medicine or dentistry, is not an exact science. Therefore, no guarantee of treatment success can be given or implied. Many factors influence the treatment outcome, e.g. the patient's general health, bone support around the tooth, strength of the tooth including possible fracture lines, shape and condition of the tooth and nerve canals, and previous work on the tooth.
2. Cases started in other offices or retreatment cases may have a different outcome than expected under optimal conditions.
3. Proper post-treatment restoration is a necessity. The patient must contact the referring dentist after completion of the endodontic therapy to arrange for the permanent restoration.
4. It may be necessary to alter the tooth structure or remove the restoration of the tooth being treated or go through existing crowns or bridgework.
5. Possible complications of treatment include, but are not limited to:
    - Procedural difficulties during the course of treatment (separated instrument, perforation, overfilling, etc.)
    - Fractures of the crown or root of the tooth
    - Persistent paresthesia (numbness) following dental anesthetics
    - Persistent paresthesia (numbness) following endodontic surgery
      If persistent numbness does occur, it will usually resolve in a few days, but there is a very small chance (less than 1%) of this lasting for months or being permanent
    - Post-surgical infection
    - Additional unknown or unspecified problems, the explanation for the responsibility of which cannot be given or assumed
6. Treatment will be performed in accordance with the standard of care and accepted techniques of clinical practice. Included in the therapy will be the taking of a minimal number of radiographs (x-rays) as dictated by the course of treatment.

Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and

(Continued)

healthcare operations; and of the used, disclosures and other important matters about your protected health information. A copy of our Notice is available at the front desk. Upon your request, we will provide a copy for your review and you are welcome to keep it. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions for our Notice at any time by contacting our office.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our practice. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent. At your request, we will provide a revocation of Consent for you to sign.

Consent for Treatment

I hereby grant authority to John B. Dale, D.M.D., P.C. to administer treatment, to administer local anesthesia, nitrous oxide (when needed) and to perform such operations as deemed necessary or advisable in the diagnosis and treatment of this patient.

Consent for Use and Disclosure of Health Information

I, the undersigned, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information, to carry out treatment, payment activities and health care operations.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Guardian (if other than Patient) **Date**

_____

Relationship