ADULT HIPAA & INFORMED CONSENT

HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
-Obtain payment from third-party payers; and/or
-Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy of Practices* from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used and/or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

INFORMED CONSENT

1. **WORK TO BE DONE**

I understand that both the dentists and dental assistants may treat me for the following dental procedures that may be necessary to provide dental treatment. I not only understand that I will be given explanation of performed treatments, but understand that the normal procedures for a first time patient may include a comprehensive or limited exam, radiographs (x-rays), fillings and fluoride application as necessary. However, this is subject to change depending on numerous factors including amount of future work needed and time.

In general terms the procedures you may need include: X-Ray, Cleaning, Deep Cleaning, Fillings, Crowns, Bridges, Extractions, Bone Graft, Impacted teeth removed, Root Canals, Full Denture, Partial Denture, Crown Lengthening, and/ or Implant.

2. DRUG AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, vomiting, and/or anaphylactic shock (severe allergic reaction).

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make those changes as necessary.

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the teeth discussed in my treatment plan.

And any other necessary treatment under paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

5. ANESTHESIA

I realize the risk involved in receiving local anesthetic, some of which are: partial facial paralysis, inflamed tissue, adverse reaction to drugs causing cardiac arrest, miscarriage, hemorrhage, never damage/numbness.

6. CROWNS, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered, and that if I don't have the permanent crowns placed permanent serious damage or lost of the tooth/teeth involved ensue, and that if I delay placement I may cause the teeth involved to move so that the permanent crown no longer will fit properly.

7. DENTURES-COMPLETE OR PARTIAL

I realize that full & partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue and bone change.

8. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that the root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily effect the success of the treatment, and that this treatment often requires multiple visits and that I can cause serious damage or loss of the tooth/teeth involved if I do not complete the prescribed treatment.

9. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I may have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions.

I hereby request and authorize the Dentists, and their staff, to perform dental work upon me for the purpose of attempting to improve my appearance, functions and the health of my mouth, teeth, bone and tissue, as explained above.

The effect and nature of the proceeding to be performed, and the risk involved, as well as possible alternative methods of treatment have been fully explained to me. I also authorize the operating Dentist and Assistant to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I know that the practice of dentistry and surgery is not an exact science and that therefore, reputable practitioners can not properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have herein requested and authorized.

Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage, and/or bleeding, scarring, contraction, possible deformity, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness and itching of the tongue, lip, teeth, tissue (Parasthesia), fractured jaw, etc., have been clearly explained to me.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature: Date:
Patient or Legal Representative

Patient Name: