

Consent and Agreement for Treatment

Please read the following information carefully. After you have read this Consent and Agreement, please sign your name below to accept the terms of this agreement.

- Consent to treat:** As a consenting adult, I agree to permit the students, faculty, staff and residents of The UT Health Science Center at San Antonio Dental School (Health Science Center-DS) to provide dental care to myself, my child or patient representative as applicable.
- Teaching facility:** As a patient of the Health Science Center-DS, all treatment will be provided by faculty or by students or residents of the Dental School under the supervision of clinical faculty.
- Limitations:** Not all persons can be accepted as patients of the Health Science Center-DS. Persons with complicated medical conditions, rigid time requirements, and extremely difficult dental care needs may not be accepted. I understand that if I am accepted as a patient, my treatment at the Health Science Center-DS may be limited, after which time I would need to find dental care outside the Dental School. As a patient of the UT Health Science Center Dental Hygiene program, I understand that receiving dental hygiene care does not guarantee future Dental School treatment.
- Emergency care:** Emergency treatment for relief of severe discomfort is available for non-Dental School patients, but during normal business hours only. The emergency treatment provided to non-Dental School patients does not mean that the Dental School will continue to provide further non-emergency care.
- Treatment Plan:** Care and treatment at the Dental School takes longer than in a private dental practice. Appointments may be up to four hours long, and I, the patient and/or the patient's representative must be prepared for multiple visits to complete my dental care needs.
- Right to discontinue treatment:** The Health Science Center-DS has the right to discontinue treatment for any appropriate reason, such as, excessive cancellations. In such cases, the patient or patient's representative agrees to accept full responsibility for pursuing alternate professional dental care. A letter will be sent informing the patient or patient's representative that treatment is being discontinued. All records pertaining to the treatment and diagnosis of patients are the property of the Health Science Center-DS. Records and x-rays will be duplicated upon written request with a reasonable charge to the patient.
- Payment for services:** I am expected to pay for the treatment I receive. The Health Science Center-DS has the right to revise fees at any time, for any procedure which has not yet been started. During the course of my dental care, unexpected complications or new conditions may arise that may result in higher cost. If my treatment becomes too complex for a dental student to manage, it may be necessary for me to be referred to one of the specialty training programs to receive the care I need. Should this occur, I understand that I will be expected to pay the specialty training program fee for the treatment.
- Risks of treatment:** The faculty at the Health Science Center-DS is available to answer any questions concerning the risks involved with specific procedures. All dental procedures have certain risks; including possible side effects from some medicines used in dentistry. These risks include, but are not limited to:
 - allergic reactions
 - cuts/abrasions
 - sensitive teeth
 - tenderness/bruising from injections

9. **Follow-up appointments:** I understand that by accepting treatment at the Health Science Center-DS I also consent to future follow-up appointments for the purpose of assessing the outcome of the dental treatment provided to the patient.
10. **Consent to photograph:** I understand that photographs, videotapes, digital, and other images may be recorded to document and assist with my care. These images may be used to assist in the education of students and residents within the institution. I understand that the Health Science Center will own these images, but that I will be allowed access to view them or to obtain copies of them at a reasonable cost. Other than for treatment and education purposes, images that identify me will be released and/or used outside the organization only upon written authorization from me or the patient representative.
11. **Notice of Privacy Practices:** The Health Science Center may release information to other entities or health care providers, for treatment, payment of services, and for health care operations as described in the "Notice of Privacy Practices". The Health Science Center has prepared this detailed document to help you better understand our policies in regard to the use and disclosure of your personal health information.

I have been given the opportunity to review and receive a copy of the Notice of Privacy Practices.

Please Initial: _____

12. **Research Study:** If my oral health problems or treatment needs could possibly qualify me for a clinical research study, I give permission for my information to be forwarded to the principle investigators.

Please Initial: _____

9. **Consent to Treatment:** By signing below, I am indicating that I have read and I understand the terms of the Consent and Agreement for Treatment. I am either the patient or have the authority to give consent for the patient. I give consent to the UTHSCSA-DS to perform necessary or appropriate tasks for proper dental and physical examination, diagnosis, and treatment, including local anesthesia.

My questions regarding this consent and agreement have been answered to my satisfaction.

Patient or Patient Representative Signature

Date

Printed Name

Relationship to Patient

Witness Name