Health Professions Divisions
College of Dental Medicine Dental Clinic

CONSENT AND AGREEMENT FOR TREATMENT AND RELEASE OF INFORMATION FOR TREATMENT AND HEALTH CARE OPERATIONS
Please read the following information carefully. After you have read this Consent and Agreement for Treatment ("Agreement") please sign your name below to accept the terms of this agreement.

1. **Screening Examination:** I understand that prospective patients will initially be given screening examination. The screening examination may include evaluation of the head, neck, teeth, gums, x-rays and other laboratory tests. I understand that the clerk will advise me of the fee for these services, examinations and/or x-rays. Until such time as I have been accepted as a patient, there will be no obligation on the Nova Southeastern University's College of Dental Medicine ("NSU-CDM") Dental Clinic to render any dental treatment. I understand that should I not be accepted, there will be no refund of any fees paid.

2. **Limitations:** The NSU CDM Dental Clinic is a teaching institution, and the selection of patients is limited and determined by the objectives of the Dental College's educational program. Not all persons can be accepted as patients of NSU-CDM Dental Clinic. Only patients who can contribute to the educational objectives of the NSU-CDM Dental Clinic can be accepted for treatment. For example: 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 NSU-CDM Dental Clinic may be limited, after which time I would need to find dental care outside the NSU-CDM Dental Clinic.

3. **Consent to Treat:** As a consenting adult, I agree to permit the students, residents, faculty, and staff of the NSU-CDM Dental Clinic to provide dental care to myself, my child or patient representative as applicable.

Patient/Representative's Initials _____

4. **Teaching Facility:** I am aware that the NSU Health Care Centers are teaching facilities, and as a result, dental residents, dental students and other dental career students will be involved in my care and treatment under appropriate supervision of clinical faculty.

5. **Emergency Care:** Emergency treatment for relief of severe discomfort or for a single procedure is available for non-NSU-CDM Dental Clinic patients, but during normal business hours only. The emergency treatment provided to non-NSU-CDM Dental Clinic patients does not commit NSU-CDM Dental Clinic to continue to provide further non-emergency care. All emergency treatment must be paid for upon completion.

6. **Time Availability:** Care and treatment at the NSU-CDM Dental Clinic takes longer than in a private dental practice. Adult appointments may be up to three hours long. Adult patients may be required to come at least one half day per week for treatment. I, the patient and/or the patient's representative must be prepared for appointment times of such duration and multiple visits to complete my dental care needs.

7. **Appointments and Cancellation Policy:** The clinic time of the student, resident and faculty is scheduled by appointment. It is essential, that all appointments be kept promptly. When an appointment cannot be kept, the clinic **must** be notified as least 24 hours in advance. Patients that miss THREE (3) scheduled appointments may be DISMISSED from the NSU Health Care Center. In the event that you are dismissed, the NSU Health Care Center will be available for emergencies during the normal hours of operation for a period of 30 days from the date of the third missed appointment to provide you with ample opportunity to select a dental provider of your choice.

8. **Right to Discontinue Treatment:** The NSU Health Care Centers have the right to discontinue treatment. 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 NSU Health Care Centers. Records and X-rays will be duplicated upon written request with a reasonable charge to the patient.

Patient/Representative's Initials _____

9. **Fees:** I am expected to pay in full for treatment I receive prior to the start of treatment, unless an alternative payment plan has been agreed upon in writing. NSU-CDM Dental Clinic 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 costs. 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.

10. **Release of Information for Payment:** I hereby authorize and consent to NSU Dental Clinic to release medical information to obtain payment as described in the NSU Privacy Notice. This authorization will include where applicable psychiatric, alcohol, drug abuse, and laboratory results of HIV Infection (Human Immune Deficiency Virus) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS). I authorize NSU to provide necessary information to the patient's insurance carrier or other payer for payment purposes, and I authorize my insurance company/payer to pay NSU for services filed on my behalf. This assignment remains effective until I revoke it in writing.

11. **Risks of Treatment:** I understand that as a patient of NSU-CDM Dental Clinic, all treatment will be provided by either students and/or residents under the appropriate supervision of clinical faculty. The students and/or residents under the appropriate supervision of clinical faculty at NSU-CDM Dental Clinic are available to answer any questions concerning the potential risks and complications involved with specific procedures, and reasonable alternatives to the proposed treatment. I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of my treatment.

12. **Follow-up Appointments:** I understand that by accepting treatment at NSU-CDM Dental Clinic I also consent to future follow-up appointments for the purpose of assessing the outcome of the dental treatment provided to the patient.

Patient/Representative's Initials _____

13. **Patient Records:** I understand that all original records and diagnostic aids, such as radiographs, and study models are the property of the NSU Health Care Centers. I understand that the NSU Health Care Centers will own the original records. I understand that I do not have the right to inspect the electronic health record system. If I request the right to inspect the record rather than obtaining a copy, the electronic health record will be printed and a hardcopy file will be provided to me for inspection at a designated time and place. I also understand that I may obtain copies of the records at a reasonable cost, upon written request, based upon established policies of the NSU Health Care Centers.

14. **Consent to Photograph:** I understand that photography, video recordings, other imaging and audio recordings ("images and/or recordings") may be recorded to document my care and treatment. I understand that NSU Health Care Centers will own these images and/or recordings. I also understand that I may obtain copies of the images and/or recordings at a reasonable cost, upon written request, based upon established policies of NSU Health Care Centers.

15. **Change of Student/Resident/Clinical Faculty:** I understand that at the time of the treatment, unforeseen circumstances may require changing which individual clinical faculty member and/or student(s) or resident(s) actually are involved in performing the treatment.

16. **Antibiotics/Analgesics/Other Medications:** I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, and cardiac arrest. I understand that I will be given a local anesthetic injection and that in rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

17. **Medical History and Follow-up:** I acknowledge that I have provided an accurate and complete a medical and personal history, including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.

Patient/Representative's Initials _____

18. **Assignment of Benefits**: I hereby irrevocably assign and transfer to NSU all right, title and interest in any benefits payable to which I may be entitled from all insurance companies, employee benefit plans, third party administrators and/or other person or entities financially responsible for my medical care and treatment rendered to me, my dependent or the insured by NSU. Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct and request that said payment of authorized benefits be made on my behalf to NSU. Where Medicaid benefits are applicable, I certify that I am a recipient of Medicaid benefits and request that said payment of authorized benefits be made on my behalf to NSU.

Patient/Representative's Initials _____

Release of Information for Treatment and Health Care Operations

By signing this form, I am consenting to the use and disclosure of my Protected Health Information ("PHI") for treatment and Nova Southeastern University's health care operations purposes for myself or for the patient for whom I am the parent or legally authorized representative. I understand that the Nova Southeastern University Dental Clinics ("NSU") will share patient PHI according to the federal and state law for treatment, payment, and operations, as well as in accordance with its Notice of Privacy Practices.

NSU's Notice of Privacy Practices provides a more complete description of these uses and disclosures. I agree that I have the right to review the Notice of Privacy Practices prior to signing this consent. I acknowledge that I have done so. NSU reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained at the NSU Dental Clinics.

I acknowledge and agree that the PHI that may be disclosed for treatment and health care operations purposes may include any or all of the following information concerning the patient: (i) any psychiatric or psychological information related to treatment of physical and/or mental illness; (ii) any information regarding drug abuse, chemical dependency or alcohol abuse; or (iii) any information regarding testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome ("AIDS"); human immunodeficiency virus ("HIV"); Sexually Transmitted Disease("STD"); Tuberculosis; Hepatitis; or other information as may be required for my treatment and health care operations.

I also consent to the release of any information to any and all business associates, regulatory and/or accrediting organizations as necessary to maintain licensure and accredited status. In addition, I consent to the release of any information to county, state or federal public health agencies, as required by law.

I understand that I have the right to request that NSU restrict how it uses or discloses the patient's PHI to carry out treatment and health care operations. However, I understand that NSU is not required to agree to the requested restrictions, but if it does, it is bound by such agreement.

I understand that I may revoke this consent in writing except to the extent that NSU has already made disclosures in reliance upon it. If I do not sign this consent, or if I later revoke it, NSU may decline to provide treatment to the patient.

Patient/Representative's Initials _____

I certify that I have read and understand the preceding Consent and Agreement for Treatment, and/or have asked and had answered to my satisfaction, any and all questions that I may have about same, by my treating student/resident or clinical faculty physician.

_____	_____
Patient or Patient Representative Signature	Date
_____	_____
Print Name of Patient or Patient Representative	Patient Date of Birth

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Description of Patient Representative's Authority

Confirmation of interpretation to Patient (if applicable)
If the patient does not read/understand English, it is the responsibility of the person who is authorized by him/her to ensure that the content of this consent form has been duly explained to him/her before he/she signs the form.

- The Patient does not read or understand English.
- I confirm that I understand the content of the consent form and I have interpreted and explained the content of the form to the patient so that he/se clearly understood what it meant before signing it.

_____	_____
Print Name of Interpreter	Relationship to Patient

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Signature of Interpreter