

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:

Examinations _____ Preventive Services _____ Restorations _____

Crowns _____ Bridges _____ Other _____ Patient Initials _____

2. Drugs and Medications

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

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials _____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials _____

Patient Signature

Date

USC PATIENT EMAIL CONSENT FORM

To address the risks of using email

Patient name: _____

Patient address: _____

Email: _____

Provider: ~~GRACE FAMILY DENTAL LLC~~

1. RISK OF USING EMAIL

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:

- a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- b) Email senders can easily misaddress an email.
- c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
- d) Employers and on-line services have a right to inspect email transmitted through their systems.
- e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
- f) Email can be used to introduce viruses into computer systems.
- g) Email can be used as evidence in court.
- h) Emails may not be secure, including at USC, and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. CONDITIONS FOR THE USE OF EMAIL

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

- a) **Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular Email will be read and responded to within any particular period of time.**
- b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.

- c) All email will usually be printed and filed in the patient's medical record.
- d) Office staff may receive and read your messages.
- e) Provider will not forward patient identifiable emails outside of USC healthcare providers without the patient's prior written consent, except as authorized or required by law.
- f) The patient should not use email for communication regarding sensitive medical information.
- g) Provider is not liable for breaches of confidentiality caused by the patient or any third party.
- h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by email, the patient shall:

- a) Avoid use of his/her employer's computer.
- b) Put the patient's name in the body of the email.
- c) Key in the topic (e.g., medical question, billing question) in the subject line.
- d) Inform Provider of changes in his/her email address.
- e) Acknowledge any email received from the Provider.
- f) Take precautions to preserve the confidentiality of email.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by email. If I have any questions I may inquire with my treating physician or the USC Privacy Officer.

Patient signature _____

Date _____

Witness signature _____

Date _____