Consent To Dental Treatment

You are requested to read the following paragraphs and to sign your name in the appropriate place if you consent to treatment of yourself at the dental clinics of Columbia University Health Care, Inc.

I hereby authorize and consent Columbia University College of Dental Medicine to the operations, procedures, techniques and clinical photographs that the dentist in attendance deem necessary for my care. I also hereby consent that any or all operations, procedures and techniques may be rendered by a student(s), resident and/or faculty member at the School. I agree to abide by all the rules and regulations of Columbia University College of Dental Medicine and Columbia University Health Care, Inc.

I understand that prior to any surgical or diagnostic procedure, technique, or taking of any clinical photograph, I will be advised by the student/resident and/or faculty member responsible for the care, and that I may ask questions concerning the treatment. I also understand that post-operative complications (for example, bleeding, pain, swelling, loss of teeth) may be a normal consequence of the treatment rendered. I further understand that I may revoke this consent before such treatment is provided.

I hereby authorize and consent Columbia College of Dental Medicine/Columbia University Health Care, Inc. to release to government agencies, insurance carriers, or others who are financially liable for the dental care, all information needed to substantiate payment for such care, and permits others who are representatives thereof to examine and make copies of all records relating to such care and treatment. However, after disclosure has been made, it cannot be revoked retroactively to cover information prior to revocation.

I understand this consent will remain in force until I revoke it in writing.

I hereby state that I have read and understood this consent form, and that I have been given the opportunity to ask questions, I might have, and that all my questions have been answered in a satisfactory manner.

ASSIGNMENT OF BENEFITS:

I hereby assign and set over to the above named Columbia University College of Dental Medicine/ Columbia University Health Care, Inc. sufficient monies and/or benefits to which I may be entitled from government agency insurance carrier or others who are financially liable for my dental, medical care to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I understand that I am responsible for charges not covered by my insurance plan.

Patient's Name: ____________________________

For whom consent for treatment is granted

Patient Signature: ____________________________

Date: ____________________________

Patients have a right to and responsibility for:

1. Understand these rights. If necessary we will supply assistance and an interpreter.
2. Receive treatment without discrimination as to race, religion, sexual orientation, disability or source of payment.
3. Receive considerate and respectful care in a clean and safe environment.
4. Receive emergency care if needed.
5. Be informed of the name and position of the persons rendering care and names and positions of administrative staff.
6. Receive complete information about their dental diagnosis, treatment, and prognosis.
7. Receive all the information needed for them to give informed consent including possible risks and benefits.
8. Refuse treatment and be told of the possible consequences of refusing that treatment.
9. After a full explanation, have a right to refuse to take part in research.
10. Privacy and confidentiality of all information regarding your care.
11. Participate in decisions regarding your care.
12. Obtain your dental record for which you may be charged a reasonable fee. You cannot be denied a copy solely because of inability to pay.
13. Receive a receipt for an explanation of all charges.
14. Complain without fear of reprisals. If you are not satisfied, you may address their concerns to the section administrator of the area of care. If you are still not satisfied, they may call the Office of Clinic Administration at (212) 305-8624.