MICHIGAN PERIODONTICS & IMPLANTS

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GENERAL CONSENT FOR TREATMENT

I consent to be a patient at Michigan Periodontics and Implants authorize the dental provider to provide radiographic and clinical examination as well as any treatment that is required in all phases of dentistry.

- I will provide a thorough and complete medical history and supply a list of medications and dosages.
- I consent to the dental provider to communicate with other medical practitioners to inquire about concerns in the health history.
- I authorize the dental operation(s) or procedure(s) (before, during or after) may be photographed and/or videotaped for purposes related to care and treatment and/or purposes of dental/medical education.
- I understand that Michigan Periodontics and Implants reserves the right, at any time, to discontinue treatment for any reason. In such cases, I to be personally responsible for obtaining other professional dental care that may be required. Michigan Periodontics and Implants will provide emergency care for up to 30 days to facilitate your transition to another dental provider.
- I understand and agree to be personally responsible for paying fees for treatment rendered at the end of each appointment. Some procedures require payment before and during the dental treatment and I will be informed of the payment responsibilities for those treatments.
- I understand Michigan Periodontics and Implants will send the bill for the fee to someone else ONLY with the understanding that patient, parent or guardian is responsible for payment, if payment does not occur by a third party, including insurance companies.
- I understand no guarantees can be made about treatment outcomes, restoration longevity, or prognoses. As in ALL dental procedures, there are some risks and potentially some unanticipated results including but not limited to:
    - Allergic reactions to medications and/or anesthetics
    - Accidental cuts and/or abrasions
    - Temporary prolonged or permanent numbness and/or tingling of lower lip and/or tongue
    - Post-operative bruising and/or discomfort
    - Drug interactions and/or side effects
    - Failure of procedure
    - Post-operative infections
- I understand that regular periodontal cleaning and follow ups as recommended by Michigan Periodontics and Implants are imperative to improve chances of success of my treatment; and if I do not follow up with recommendations, this may result in failure of the treatment and I will not hold Michigan Periodontics and Implants and/or Dr. Kinaia liable.
- I authorize the operation or procedure (before, during or after) to be photographed and/or videotaped for purposes related to care and treatment, social media and/or purposes of dental/medical.
- I agree in accordance with State law, an HIV or HBV test may be requested to be performed upon me/the patient in the event a health care worker sustains a significant exposure to my/the patient's blood or body fluids. The results of any test will be treated confidentially.
- I understand that I am responsible for clarifying any aspects of the dental treatment that I am unsure about. I will ask questions about any aspect of the dental care (to include risks, benefits and alternatives) and will request information if I am confused or need more information.

- By signing below, I am saying that I consent to Michigan Periodontics and Implants to provide dental treatment and to perform those tasks including local anesthesia, necessary or appropriate for the proper dental examination, diagnosis and treatment. I also give permission to Michigan Periodontics and Implants to use, share and disclose protected health information, including sensitive health information about HIV/AIDS status, sexually transmitted or other communicable diseases, and mental health, alcohol and drug abuse, as they see necessary for the purposes of treatment, payment, health care operations or other purposes authorized by law. These purposes may include, but are not limited, to disclosures to insurance companies, to state and federal government programs, and worker's compensation programs for the purposes of claim processing and payment or to other health professionals for treatment.
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- I acknowledge that I have received or been offered a copy of the Michigan Periodontics and Implants Notice of Privacy Practices.

We invite your questions concerning this or related procedures and their risks. By signing below you acknowledge that you have read this document, understand the information presented and are choosing care from the treating provider and have had all your questions answered satisfactorily.

_____	_____	_____
Patient Name	**Signature**	**Date**

OR

_____	_____	_____
Parent/Legal Guardian/Patient Advocate	**Signature**	**Date**