UNIVERSITY OF NEW ENGLAND
Oral Health Center

Oral Health Center
1 College Street
Portland, ME 04103, USA
(207) 221-4747 T
(207) 221-4805 F
OralHealthCenter@une.edu E
www.une.edu/ohc

PATIENT INFORMED CONSENT

Patient Name:

DOB:

GENERAL INFORMATION: *Thank you for choosing the University Of New England College Of Dental Medicine for your oral health care needs.*

Our goal is to provide you with exceptional dental care and the opportunity to understand all treatment available for you and your treatment options. It is important that you understand the benefits, risks, time frame and costs of your treatment.

Please read this document and ask questions. We are happy to clarify any questions or concerns that arise and we look forward to discussing these with you.

During the course of your care you will be seen by our faculty dentists and our dental student clinicians under the supervision of the faculty.

Since we are an academic oral healthcare center your appointments may take longer than treatment at a private practice. While students consult with faculty you will have the opportunity to ask questions and be part of our exciting patient focused academic environment. As a benefit of participating in this educational process you will notice that our fees are less than a private practice. We appreciate that you are a vital part of our Oral Health Center and look forward to being your partner in good health.

CONSENT TO DENTAL PROCEDURES: *As a patient you will have access to current and complete information about your condition. In order to address your particular dental care needs as well as the educational process your treatment may be provided by multiple student dentists. Before beginning specific treatments you will be presented with a properly sequenced treatment plan that includes an estimate of the cost. Before receiving treatment you should feel comfortable asking the student dentist about the procedure(s) recommended for you, and ask any questions you may have before you decide whether or not to give consent. All dental procedures may involve risks of unsuccessful results and complications, and no guarantee is made as to result or cure. You have the right at all times to be informed of any such risks as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of no treatment. You have the right to consent to or to refuse any proposed procedure prior to its performance.*

EMERGENCY CARE: *Emergency dental treatment is intended to provide relief of severe pain and infection for individuals in acute need. If you are accepted into the UNE- OHC program and become a patient of record, you will have access to a 24 hour dental emergency service. There may be a charge associated with this service.*

X-RAYS: *Digital dental radiographic images will be taken and examined when necessary and appropriate for evaluation, diagnosis, consultation and treatment.*

FINANCIAL RESPONSIBILITY: *Patients are responsible for full payment for all dental care services at the time they are provided. In order for you to be prepared to pay at each appointment, fees (or fee estimates) for scheduled procedures will be provided to you before scheduling for each appointment. You will be charged for treatment according to the fee schedule in effect at the time of treatment.*

DENTAL INSURANCE: *The UNE Oral Health Center accepts insurance assigments from Northeast Delta Dental and MaineCare only. As a courtesy, we will will assist you with dental insurance submission by providing a coded and itemized list of the treatments rendered to you so that you can submit this to your insurance carrier and receive your reimbursement. The portion of the fee the patient is responsible for is due at the time of the appointment.*

DENTAL MEDICAL RECORDS: *The dental medical record, radiographic images, photographs, videos, models and other diagnostic aids relating to your treatment are the property of the UNE Oral Health Center. You have the right to inspect such materials and to request a copy of your dental medical records and radiographic images. A reasonable fee may be required for copying these items. You may also request to have your dental radiographic images sent to another health care provider by signing a Release of Information form. The UNE Oral Health Center complies with requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the House Information Technology for Economic Clinical Act. You will receive separate information, forms, and consents in that regard.* **In addition, your dental medical record may be used for educational purposes. If used, your identity will not be disclosed to individuals not involved in your care and treatment.**

KEEPING YOUR APPOINTMENTS: *Because the educational process revolves around patient care, it is important for you to be on time for your appointments. If you find that you are unable to keep an appointment, you agree to notify the student dentist or the patient care coordinator at least 48 hours in advance. A total of two cancellations without 48 hours notice, more than two missed appointments, or repeated unsuccessful attempts to arrange an appointment may result in the discontinuance of further treatment at the UNE Oral Health Center*

DISCONTINUANCE OF TREATMENT: *The UNE Oral Health Center reserves the right to discontinue dental treatment whenever it is considered advisable and in the best interest of you or the UNE Oral Health Center teaching program. Should treatment be terminated, any remaining credit balance for services not yet provided will be refunded to you.*

AUTHORIZATION: *If I am accepted as a patient of record in the UNE Oral Health Center program I understand that a student dentist(s)s under the supervision of a licensed dentist will explain to me the nature of the procedure, the expected benefit, the availability of alternative methods of treatment with corresponding fees and the risks of no treatment. I hereby acknowledge, agree and give my voluntary consent for treatment provided through the UNE Oral Health Center that includes, but is not limited to, routine diagnostic procedures, laboratory tests, x-rays and other treatment as prescribed. I understand that my treatment may include a variety of interventions. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at UNE Oral Health Center. I acknowledge that my care is under the direction of my treating professional(s) and I represent that I will follow the instructions of my professional(s) in the provision of said care.*

Your signature on this form certifies that you have read and understand the information provided on the form, that you have received a copy, and that you accept dental care and treatment under described terms and conditions.

Date: Signature: _____

If signed by other than the patient,
Indicate relationship: parent or legal guardian:

Witness Signature: _____