CEDAR POINTE
PROSTHODONTICS

DR. MICHAEL N. DANIELAK
Board Certified Prosthodontist
DDS, Cert. Pros, FRCD(C)

CONSENT TO INTIAL EXAMINATION AND/OR INITIAL TREATMENT

Patient Name: _____ Date: _____

I hereby authorize:

1. The doctor(s) at Cedar Pointe Prosthodontics to take radiographs, study models, digital scans, photographs, or any other diagnostic aids that are deemed appropriate to make a thorough diagnosis of my dental condition(s).

I understand that:

2. Unless emergency care is required, treatment for elective procedures will not commence until there has been, at minimum, a thorough verbal discussion of my intra-oral condition, treatment options (along with expected risks and benefits), proposed treatment sequence, treatment timing, and the financial commitment. Treatment will commence only after I have provided informed consent to the prior discussion.

3. If my dental needs require a formal (written) treatment letter to be generated, it will include a review of my intra-oral condition, diagnosis, treatment options (along with expected risks and benefits), proposed treatment sequence, treatment timing, and the expected financial commitment.

4. If a formal treatment letter is developed, presented, and accepted, only an estimate of the costs of treatment will be listed. I further understand that change(s) in an accepted treatment plan may be necessary during the course of treatment, and that any change(s) will be discussed prior to initiation of the modified treatment (along with the expected change in the estimate of treatment cost).

5. Treatment will be performed by the dental specialists and auxiliary staff at Cedar Pointe Prosthodontics. If additional treatment is required by another dental specialist, I understand that a referral will be made to another dental specialist for that particular aspect of dental treatment. The treatment performed at other dental specialist offices *may* or *may not* be factored into the estimated cost of treatment provided on the treatment plan provided by Cedar Pointe Prosthodontics.

I acknowledge that:

6. I will receive no guarantees or assurances about the outcome of any treatment or its components.

I fully understand the conditions of this consent and have had the opportunity to have my questions and concerns related to this consent answered to my satisfaction.

_____

Signature: □ Patient □ Parent □ Guardian

632 Yonge Street, Unit C6
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CONSENT FOR COLLECTION & USE OF PERSONAL HEALTH INFORMATION (PHI)

Patient Name: _____ Date: _____

The Government of Canada has created a federal privacy law for medical establishments known as the Personal Information Protection and Electronic Documents Act (PIPEDA). This law was created to help ensure that personal health information (PHI) is protected for privacy purposes. It was also created in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. The PIPEDA Notice provides information about how this office may use and disclose your personal health information (PHI) and also describes your rights under the law. The PIPEDA Notice may change at any point in time; you may contact the office for a revised copy.

This office respects the privacy of your personal medical records and reasonable precautions are taken to protect and keep your personal health information (PHI) safe and secured. When it is appropriate and necessary, the minimum necessary information is provided to only those who need of it (such as another dental professional or third-party insurance company) including information about your treatment, payment, or health care operations.

You have the right to review the PIPEDA Notice, detailing how your personal health information (PHI) may be used and disclosed as permitted under federal and provisional law, as well as outlining your rights regarding personal health information (PHI) use. You may refuse to consent to the use or disclosure of your personal health information (PHI), but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information (PHI).

If you choose to give consent to this document in the present, at some future time, you may request (in writing) to revoke all or part of this consent. However, such a revocation shall not affect any disclosures of PHI that have already been made in accordance on your prior consent.

I understand that:

1. My protected health information (PHI) may be disclosed or used for treatment, payment, or health care operations, or for other purposes permitted or required by law.
2. The office has a printed PIPEDA Notice and that I have had an opportunity to review it.
3. I may revoke this consent in writing at any time, and all future disclosures will then cease.
4. I have the right to restrict the use of my PHI, but the office does not have to agree to the restrictions.
5. The office is not obligated to provide treatment if I do not consent to and sign this form.

By signing below, I acknowledge that I have been allowed to review the PIPEDA Notice, which contains a detailed description of the uses and disclosures of my personal health information (PHI).

☐ I deny my consent to this form.
☐ I wish to restrict the following information: _____

_____

Signature: □ Patient □ Parent □ Guardian

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