Informed Consent to Treatment Plan Form

Name of Patient: _____

Date of Treatment Commencement: _____

Duration of Treatment: _____

Denturist Providing Treatment: _____

1. I authorize the above referenced provider or whomever he/she may designate to perform the treatment as outlined in the attached signed detailed treatment plan.

2. The nature and purposes of the treatment, possible alternative methods of treatment, the risks involved and the possible complications have been fully explained to me by the above referenced provider.

3. I acknowledge that no guarantee or assurance has been made to me in regards to the results that may be obtained. The average life expectancy of the treatment(s) has been provided.

4. I understand this Informed Consent to Treatment form and the treatment as described in paragraph 1 as explained to me by the above referenced provider.

5. I confirm that I have discussed the estimated cost, future costs and method and terms of payment for the treatment with the above referenced provider and that I have agreed to make such payment on the terms we discussed.

BY INITIALING HERE "_____", I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT AND THAT THE EXPLANATIONS REFERRED TO WERE IN FACT MADE TO ME AND THAT THE FORM WAS FILLED IN PRIOR TO TREATMENT. I ALSO CERTIFY THAT I WAS GIVEN AN OPPORTUNITY TO ASK QUESTIONS AND ALL OF MY QUESTIONS HAVE BEEN SATISFACTORILY ANSWERED. BY SIGNING BELOW, I ACKNOWLEDGE MY UNDERSTANDING OF THE INFORMATION ABOVE AND THAT I AGREE TO PROCEED WITH TREATMENT AS PROPOSED.

Signature of Patient: _____

Or

Signature of Parent/ Guardian/Power of Attorney: _____
(substitute decision maker)

Date: _____

Witness: In my opinion, the patient/parent/guardian appears able to understand the treatment proposed and the information provided concerning the treatment.

Signature of Witness: _____

Date: _____