Moss Street Healthcare Centre

Consent to Treatment

Patient Name:_____

1. I authorize the dental treatment plan on _____(State "myself" or name of patient).
2. The material risks* and benefits of the accepted treatment plan have been explained, and I fully understand them.
3. Alternative treatment plans to the one accepted by me have been presented including their benefits and material risks.
4. I acknowledge that I have received no guarantees or assurances about the outcome of the treatment or any of its components.
5. I understand that changes in the accepted treatment may be necessary during the course of treatment and that I will be informed of these changes.
6. My signature and date on the line following any treatment plan change(s) or additions(s) will certify my knowledge, awareness and acceptance of the modifications.
7. I fully understand the conditions of this consent and have no additional questions.
   *material risks are those complications which may occur despite all precautions, during or following treatment or procedure, which may influence the person from whom consent is sought to refuse the treatment, postpone it, or to seek another opinion before proceeding.

Initial treatment Plan Agreement: Date:_____

_____ _____

Signature of Patient or Authorized Representative If Authorized Representative, state relationship

_____ _____

Witness Signature Doctor Signature