School of Dental Medicine
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

General Information and Consent for Treatment

Welcome and thank you for your interest in the University of Colorado School of Dental Medicine (CUSDM). The School of Dental Medicine is able to provide dental care to many patients while providing a clinical education for our dental, international, post-graduate students and residents.

General Information:

The University of Colorado School of Dental Medicine accepts patients for treatment regardless of race, color, national origin, pregnancy, sex, age, disability, creed, religion, sexual orientation, gender identity, gender expression, veteran status, political affiliation, or political philosophy

Clinical Teaching Setting: Students and or residents provide all treatment, with the exception of treatment provided in the Dental Faculty Practice (DFP). The care provided by students and or residents is under the supervision of the clinical teaching staff. Because of the complex nature of some dental treatments, not all patients can be treated in a school setting. Students/residents require more time to complete care than in a private dental setting.

Patient/Provider Availability: Student, resident, and faculty availability in the teaching clinics is limited due to academic requirements. Patients must have a flexible schedule and must keep their appointments. The student/resident must be notified at least 48 hours in advance to a change or cancellation of an appointment. Treatment may be discontinued for patients who miss more than two appointments without prior notice, or for patients who are unable to keep an effective appointment schedule (excessive cancelled appointments, late to appointments, etc.).

Patient Identification: CUSDM takes steps to help ensure the security of our patient's personal information. This process is done by verifying the identity of all patients during their visits to CUSDM. All patients are required to present valid photo identification such as a Colorado driver's license, Colorado identification card, passport or other government-issued photo identification at each appointment. In addition, all patients at the initial appointment will be photographed for ongoing patient identification.

Interpreter Services: CUSDM has free Interpreter Services available upon request for patients during the course of treatment at the School of Dental Medicine. This includes interpreter services when patients do not speak or understand English as well as for the hearing and visually impaired.

Fees and Payment of Services: Services are provided on a pay as you go basis. Payment plans are not available, with the exception of selected orthodontic treatment. Patients are expected to pay for services at the time of the appointment; failure to provide payment may result in cancellation or rescheduling of appointment(s). Cash, personal checks, Visa, MasterCard, Discover, and American Express are accepted forms of payment. Insurance payments and Medicaid are accepted; those charges not covered by insurance remain the responsibility of the patient and are due at the time of service.

Emergency Services: CUSDM provides emergency care for patients of record in good standing in our programs. Emergency care for patients who are NOT currently enrolled in our programs may be provided on a fee-for-service basis in the walk-in Emergency and Urgent Care Clinic. It should be noted that all fees must be paid at the time treatment is provided, and service is limited to diagnosis (finding the cause) of the patient's emergency and if appropriate, treatment to control pain and or infection.

Limited Care Treatment: Patients referred for limited dental treatment(s) may be accepted for care on the tooth/teeth listed in the referral document. This is the only treatment CUSDM will provide and further dental care should be provided by the referring dentist. Patients are required to follow payment policies listed. Should further dental care be necessary, the patient will need an additional referral or to pay for an oral diagnosis exam.

Notice of Privacy Practices: CUSDM may release information to other entities or health care providers, for treatment, for payment of services and for health care operations as described in the "Notice of Privacy Practices."

Right to Discontinue Treatment: CUSDM has the right to discontinue care for any appropriate reason, such as excessive missed appointments, disruptive personal behavior, or lack of compliance to prescribed therapies. In such cases, the patient or patient's representative agrees to accept full responsibility for pursuing alternate professional dental care. A letter will be sent out informing the patient of the treatment that is discontinued. All records pertaining to treatment and diagnosis are a property of CUSDM. Records and x-rays may be duplicated upon written request with a reasonable charge. If care is discontinued, CUSDM will provide emergency care, on a fee-for-service basis, for 45 days from the date of the discontinue notice.

Risks of Dental Treatment: The faculty at CUSDM is available to answer any questions pertaining to risks of procedures. All dental procedures have certain risks, including possible side effects from some medicines used. The risks include, but are not limited to: allergic reactions, cuts/abrasions, tenderness/bruising, and tooth sensitivity.

General Dentistry Informed Consent for Treatment

This consent for treatment includes but is not limited to:

- Local anesthesia and medicines
- Radiographs, photographs
- Extracting teeth
- Dental Cleanings including Scaling and Root Planing
- Crowns
- Bridges
- Restoring teeth with fillings
- Root canals
- Dentures
- Dental Implants
- Dental surgery
- Other

I understand that specific informed consents may be required for any or all of the above procedures. I understand that because of the very nature of any proposed treatment and the uniqueness of myself as an individual, no one can predict the certainty of any outcome or success of any dental treatment. I understand that dental treatment contains no guarantees, warranty, or assurance of success. Each individual case is unpredictable making it impossible to surmise results. I further understand that the results may NOT be to my complete and full satisfaction after treatment is complete and my condition may be the same, better or worse.

I have had an opportunity to ask questions about any policies of CUSDM. These questions have been answered to my complete satisfaction.

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I have received CUCSDM Patient Rights and Responsibilities.

I have given an accurate reporting of my medical, mental, and dental health issues.

I consent to the taking of photographs, slides, videotapes, models, intraoral scans, and x-rays of my oral and facial structures and the collection of my extracted teeth. I also consent to the use of de-identified patient information, photographs, slides, videotapes, models, intraoral scans, x-rays of my oral and facial structures and extracted teeth, for publication, education, scientific, and research purposes. I give permission for CUSDM to contact me in the future to ask me to take part in research studies.

I give permission to CUSDM to send copies of my dental records, including radiographs, to the referring dentist when requested.

I give permission for CUSDM to contact me using email, text and phone notifications to remind me of the date and time of my appointments and other general appointment information. I may opt out from receiving notifications.

I understand that if a prescription is written for a controlled substance, state law requires that certain prescription information, including my name, be entered into a secure database (Colorado's prescription drug monitoring program) when I fill this prescription at my pharmacy. Authorized prescribers of controlled substances and law enforcement, in limited circumstances, may access the database for allowed uses.

I authorize the faculty, residents and students of the University of Colorado School of Dental Medicine to provide Emergency Care to me or the minor listed on this form.

I understand all of the above patient information contained on this document and agree to abide by all of the procedures and conditions specified. I hereby give permission for diagnosis and /or treatment at the University of Colorado School of Dental Medicine for myself or for the minor child named in this document.

ELECTRONIC SIGNATURE TO BE ACQUIRED