



Dental Consent Contract

Consent for Dental treatment

Read Carefully – This is a contract

I consent to receiving services at the Dr. Gary Burnstein Community Health Clinic. This treatment may include assessment, routine diagnostic procedures, medications, and appropriate dental treatment as the attending Dentist/Dental Hygienist/Oral Surgeon considers necessary for my care. I acknowledge that no guarantees have been made to me as to the result of examination or dental treatment at this clinic.

I understand that the services I receive at the Dr. Gary Burnstein Community Health Clinic, or as a result of a referral from GBCHC, are being provided by health care practitioners and lay volunteers who are not receiving compensation and compensation will not be requested from any source. I understand, as provided by Federal and Michigan State Law, that these volunteers are not liable for civil damages as a result of acts or omissions which may occur in providing services to me, except acts or omissions amounting to gross negligence or willful and wonton misconduct or were intended to injure me.

I understand that and verbally abusive or threatening behavior to the clinic staff is grounds for the termination of clinic services.

Falsifying my income information is grounds for the termination of clinic services.

In the event that any agent of the GBCHC is contaminated in any way with my bodily fluids, blood samples will be drawn from both parties to test for communicable diseases.

I understand that clinic resources are limited and valuable. By not cancelling appointments I am unable to keep, I am taking away an appointment from someone else. I understand that any “no show” visit is grounds for termination of clinic dental services. Cancellations must be made more than 24 hours before your scheduled appointment.

My signature below constitutes my acknowledgement that I understand this request for consent and that I agree to its contents.

Date

Print Patient’s Name

Signature of Patient or Responsible Party

Relationship to Patient

Signature of Witness