JULIAN C. LEICHTER, D.M.D., P.A.

Consent to Treatment

I hereby consent to periodontal treatment by Dr. Julian C. Leichter and his auxiliary personnel. Treatment shall consist of diagnostic, therapeutic and surgical services designed to control periodontal diseases and aid in the establishment of a healthy dentition.

I understand that treatment may require the use of topical and local anesthetics, sedation and analgesia. I am aware of the possible complications of treatment, including swelling, bleeding, pain, nausea, diarrhea, elevated temperatures, rash, constipation, tissue discoloration, sinus entry, paresthesia, anesthesia (numbness), sensitive teeth, esthetic alteration (increased length of teeth, exposed crown margins, increased spacing between teeth, etc.), phonetic (speech) changes and increased food impaction.

I further authorize such additional treatment as may be indicated by sound and prudent dental practice if, during the course of treatment, unforeseen conditions are discovered or unusual situations develop. I understand this may include (but shall not be limited to) the removal of individual teeth or roots and the implantation of grafting materials including those obtained from tissue banks.

I understand that my cooperation in helping to control the etiologic (causative) factors of periodontal diseases plays an important role in the success of treatment. I am aware that smoking increases the incidence and severity of periodontal/peri-implant disease and may significantly delay and ultimately prevent proper healing. I also understand that ideal treatment does not preclude the possibility that one or more teeth or tooth replacements may be lost.

The nature and purpose of the treatment to be rendered, the discomforts and possible hazards involved, and alternative methods of treatment have been explained to me by the doctor and his staff. Preoperative and postoperative instructions have been reviewed and all questions regarding my care have been thoroughly answered.

Although it is believed that the results of treatment will be optimal, no guarantee of a degree of success or of my complete satisfaction has been made. I understand that fees are not refundable and any disagreement, controversy or claim relating to my care shall be settled by arbitration in accordance with the provisions of the Florida Arbitration Code.

I consent to the use of x-rays and photographs of my treatment for educational, documentary or scientific purposes. I understand that confidentiality shall be respected. I certify, with sound mind and body, that I have read and understand the above Consent to Treatment as well as the Preoperative and Postoperative Instructions.

Patient Signature ____ Date ____________

I have personally confirmed that the patient whose signature appears above has read and understands this document. I have answered any questions and explained all of the treatment to be performed including the preoperative and postoperative procedures.

Staff Signature ____ Date ____________

seven thousand west camino real • suite 120 • boca raton, florida 33433 • 561/391-1800

JULIAN C. LEICHTER, D.M.D., P.A.
7000 West Camino Real, Suite 120
Boca Raton, FL 33433

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ______________________________, hereby authorize Julian C. Leichter, D.M.D., P.A. and the doctor and
PRINT NAME

professional staff of this practice (hereafter collectively referred to as "Practice") to use and disclose the entire medical record concerning ________________________ in accordance with the attached Notice of Privacy Practices (NOPP).
PRINT PATIENT'S NAME

I have reviewed the NOPP, been given the opportunity to ask questions about it, understand it and do hereby agree to its terms. I also herby authorize the Practice to request and obtain my entire medical record from any other health care provider or entity, either verbally, by mail, or unencrypted e-mail. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I especially authorize Practice to use and disclose verbally, by mail, fax or unencrypted e-mail, the following types of super-confidential information as stated in the NOPP, except (initial if appropriate):

______ HIV records (including HIV test results) and sexually transmissible diseases

______ Alcohol and substance abuse diagnosis and treatment records

______ Psychotherapy records

____
SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

____
PRINTED NAME OF PATIENT OR PATIENT'S REPRESENTATIVE

____
RELATIONSHIP OF PATIENT'S REPRESENTATIVE TO PATIENT (IF APPLICABLE)

____
DATE