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DIAGNOSING & TREATING
THE ORTHODONTIC
DENTO-LEGAL
HORRENDEOMA

AN INTEGRATED
MANAGEMENT

RISK MANAGEMENT
PATIENT MANAGEMENT
PRACTICE MANAGEMENT
FISCAL MANAGEMENT

SEMINAR SERIES
PRESENTATION

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RELEASE FROM LIABILITY FOR REMOVAL
OF ORTHODONTIC APPLIANCES AGAINST MEDICAL ADVICE

This is to certify that I, (Parent’s or Patient’s name), voluntarily requests the removal of [my / my child’s] (Insert patient’s name if a minor) orthodontic appliances and the termination of my / his / her orthodontic treatment.

I have been informed that [my / my child’s] orthodontic treatment is not completed and that (Doctor’s name*) strongly recommends the continuation of treatment in order to obtain the best possible result. In addition, I have been informed of and I understand the probable negative consequences that may occur as a result of my discontinuing treatment before it is completed and against the advice of (Doctor’s Name*).

I hereby release (Doctor’s name*) from any responsibility and for any and all injuries or damages that I may suffer both presently and in the future as a result of my decision to terminate my / my child’s treatment against the sound medical advice of my orthodontist.

________________________________
Signature of Patient       Date

Witness                  Date

* NOTE: If Dr. is a professional corporation, partnership, LLC, etc. or has any associate doctors providing treatment in the office, place the name of the business entity, the names of everyone who treated the patient as well as the Doctor’s personal name in this space.
PATIENT STATUS REPORT

To:
Date:
Re:

TREATMENT TIME:
[ ] progressing according to schedule
[ ] progressing ahead of schedule
[ ] progressing behind schedule

COMMENTS: ____________________________________________________
_____________________________________________________________
_____________________________________________________________

TREATMENT GOALS:
[ ] unchanged
[ ] altered treatment objective

COMMENTS: ____________________________________________________
_____________________________________________________________
_____________________________________________________________

HYGIENE:
[ ] within normal limits
[ ] needs treatment
[ ] told patients to call your office
[ ] suggest you recall patient

COMMENTS: ____________________________________________________
_____________________________________________________________
_____________________________________________________________

COOPERATION LEVEL:
[ ] good   [ ] average   [ ] poor

COMMENTS: ____________________________________________________
_____________________________________________________________
_____________________________________________________________

UNIQUE FEATURES / GENERAL COMMENTS: ____________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

Respectfully,
Dear: ___________________________

We are encountering problems with your / your child’s cooperation which may result in achieving less than a desirable orthodontic result. The problems so far are:

- [ ] not brushing teeth, gums and appliances as instructed.
- [ ] not wearing rubber bands as required.
- [ ] not wearing the Head Gear/ Night Brace the required amount of time.
- [ ] not wearing or caring for the removable appliance(s) as instructed.
- [ ] eating foods that break or loosen the appliances.
- [ ] not keeping regularly scheduled appointments.
- [ ] whatever else you want to place in this section

Patient cooperation is essential if we are to achieve the best result possible. Please see what you can do to address and rectify the above noted concerns. If you wish to discuss this matter with us, please feel free to call.

Respectfully,
LETTER TO DENTIST REGARDING POOR PATIENT COOPERATION / RESULT

Dear Dr. ______________:

As you know we are currently providing orthodontic care for ____ (Patient’s Name) ___. Even though we are giving our closest attention to ____ (Patient’s Name) ____ case, his/her response to treatment has been slower than normally expected. The problems to date appear to have been * (insert from categories below) ___.

We will continue with ____ (Patient’s Name) ____ treatment as long as it is clinically feasible to do so in order to achieve the best possible clinical result. However, due to the situation as previously described, some limitations or compromises regarding our initial treatment goals may occur.

If you have any questions, please call us. You may wish to recall ____ (Patient’s Name) ____ at this time to examine him/her and re-enforce to him/her and his/her parents, the positive benefits of orthodontic therapy and the cooperation needed to achieve these ends. We have discussed this with ____ (Patient’s Name) ____ parents so they are aware of the situation.

Respectfully,

*i.e.:*  
- not wearing headgear or elastics as instructed  
- not complying with oral hygiene instructions  
- not keeping appointments  
- poor skeletal growth/response  
- slow dental development  
- other: __________________________________________
DISMISSAL LETTER

Dear __________________________:

Due to the fact that (choose from one or more of the six categories below) we must inform you that we are withdrawing from rendering further professional attendance to (your / your child’s) orthodontic needs.

Since (her / his / your) dental condition requires further treatment, we urge that you seek continued orthodontic care and treatment with another orthodontist without delay.

If you wish, we will be available to attend to any orthodontic needs you may have for the next (30, 45, 60) days on an emergency basis only or to help you with a referral or to in seeking another doctor. This should give you ample time to select another orthodontist. If you need help in finding another orthodontist, please contact us in this regard. (If the patient calls, you can (1) give them the names of a few doctors in your area; (2) copy a page or two from the phone book; (3) give the patient the phone number of a local teaching hospital, clinic or school; (4) or, provide the patient with the number of the local dental society for their referral base).

Should you authorize the release of your / your child’s orthodontic records, we will be happy to forward them to you or the orthodontist of your choice along with any other clinical information concerning the diagnosis and treatment rendered by us. (If you are charging a fee for duplicating records, state that here).

We regret having to take this action but the situation as noted above has left us no other option.

Respectfully,

1- there has been a lack of cooperation regarding following instructions which has been very detrimental to (your / your child’s) dental health thus potentially compromising our ability to achieve an adequate orthodontic result,

2- we are unable to agree on a viable approach to correct your orthodontic problem,

3- we are unable to coordinate the scheduling of appointments which in turn is jeopardizing (your / your child’s) treatment; and, after repeated attempts have still been unable to do so,

4- you have not kept up with your financial obligations, under the terms that you agreed to, to pay for orthodontic services rendered,

5- you have not been honest and forthright in dealing with our office regarding the professional services rendered,

6- there are significant interpersonal differences and problems between (you / your child) and members of our office staff which have created disharmony and/or disruption to our daily office routine and activities
PHYSICIAN’S LETTER WITH RELEASE

Date:

Re:

Dear Dr.

I would appreciate your letting me know if you have any information in your records regarding the diagnosis or treatment of ___(Patient's Name)____ for any of the following disorders:

- allergies
- endocrine / metabolic
- respiratory
- cardiopathies
- hereditary or genetic diseases
- infectious diseases
- autoimmune diseases
- arthritic / rheumatologic

Trusting I have the pleasure of hearing from you soon, I am

Cordially,

Doctor’s Name

____________________________________________________________________

I authorize the release of the above requested medical information pertaining to myself/my child as requested by ___(Doctor’s Name)____.

__________________________
Signature of patient or parent if patient is a minor
Dear Dr. ________________________:

(Patient’s Name) is under our care for orthodontic therapy. Our medical history reveals that (Patient’s Name) has (fill in choices from 1-5 below) .

Please advise us as to the following:

1. The nature of his / her cardiac problem.
2. Whether or not you recommend prophylactic antibiotic coverage for Infective Carditis.
3. If so, should we follow the current American Heart Association regimen or do you have a different protocol you wish us to follow? *

Thank you for your prompt reply.

Respectfully,

Doctor’s Name

I authorize the release of the above requested medical information pertaining to myself/my child as requested by Dr. ________________________.

________________________________________
Signature of patient

________________________________________
Signature of parent if patient is a minor

1 - a heart murmur
2 - had Rheumatic Fever
3 - had prosthetic joint replacement
4 - mitral valve prolapse
5 - unspecified cardiomyopathy

* If the patient’s physicians recommends a different protocol by phone, request a letter to that effect in writing.
PROCEDURE PRESCRIPTION LETTER

Date:

Re:

Dear Doctor:

In conjunction with (Patient’s Name) orthodontic therapy, please: [ ] extract
[ ] expose
[ ] consult on
[ ] provide

Remarks: ____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Respectfully,
Dear Dr.

____ (Patient’s Name) _______ has been evaluated by our office for orthodontic therapy. Our examination revealed the presence of:

[ ] steep mandibular plane angle
[ ] high narrow palatal vault
[ ] open bite tendency
[ ] excessive lower face height
[ ] mouth breathing
[ ] radiographic large adenoidal tissue mass with nasopharyngeal obstruction
[ ] enlarged tonsilar tissue mass
[ ] deviated septum
[ ] engorged turbinates
[ ] history of allergic rhinitis
[ ] __________________________

As you are aware, upper airway obstruction can significantly affect one’s dentofacial growth and development. Untreated obstructions can also seriously affect the stability of any orthodontic treatment rendered. Please examine _____ (Pt.’s Name) _______ regarding the above noted factors and evaluate him/her for any necessary treatment of any airway obstruction since an aggressive early approach has been proven to have beneficial effects regarding a patient’s dentofacial development.

If you wish to discuss _____ (Patient’s Name) _______ case with us, please feel free to call.

Respectfully,

Doctor’s Name

cc: Allergist
    Pediatrician
    Dentist
    ENT Physician
PERIO LETTER TO D.D.S.

Date: 
Re: 

Dear Dr. ____________________:

Please evaluate the need for:

[ ] oral hygiene instruction
[ ] prophylaxis
[ ] deep scaling & curettage
[ ] other ________________________

as __________(Patient’s Name)_____________ present oral environment is not compatible with the (initiation of / continuation of) orthodontic treatment.

In addition, please evaluate the following mucogingival areas / tooth numbers for the following procedures in conjunction with __________ Patient’s Name treatment.

Area / tooth Number(s): ______________________________________________
____________________________________________
____________________________________________

Procedures:
[ ] frenectomy
[ ] supercrestal circumferential fiberotomy
[ ] free gingival graft
[ ] gingivectomy
[ ] gingivoplasty
[ ] apically repositioned graft
[ ] crown lengthening
[ ] exposure
[ ] implant / TAD
[ ] ________________________

If you feel that more extensive treatment or therapy is indicated, please inform our office so that we may aid in any way possible and also to allow us to reschedule the patient accordingly.

Respectfully

Doctor’s Name
NOTE: The laws regarding informed consent vary from State to State. Some States require that the doctor transmit information concerning the patient’s diagnosis and treatment in accordance with what other reasonable practitioners would tell their patients under like circumstances. Other States require a practitioner to divulge any information that a reasonable patient may find material in determining whether to accept or reject the proposed treatment. The generic protocol listed below, was developed to be acceptable in most if not all States. The following is generally required to defeat claims for lack of informed consent.

INFORMED CONSENT

DIAGNOSIS: Should be transmitted in language that the patient or parent can comprehend; i.e: “you’re bottom jaw is too far back”…NOT “you have a mandibular retrognathia” or “your overjet is 6 mm”.
- The information can be transmitted in any medium. 
  i.e.: CD-ROM, video, booklet, consultation, etc.
- The information can be transmitted by any person.
  i.e.: the doctor, treatment coordinator, etc.

TREATMENT PLAN: Again, this information should be delivered in a plain understandable language.
- what you are going to do
- why you are doing it
- the length of time that treatment should take
- the fee for all services
- mechanotherapeutic approach to be employed
- required cooperation on the part of the patient

ALTERNATE TREATMENT PLANS:
- all viable treatment plans should be discussed, even if not practiced by you
- any necessary secondary treatment

RISKS, CONSEQUENCES, AND LIMITATIONS: Disclose to the patient, all probable risks, consequences and limitations for all treatment plans discussed.
- not every risk need be disclosed, only those that a reasonable patient might deem to be material in deciding whether or not to accept or deny treatment
- you only need to disclose just those that are probable consequences that might be encountered by an average patient, with this condition, undergoing this specific type of treatment.

PROGNOSIS AND EXPECTATIONS: Its just as important if not more so to tell the patient what orthodontics cannot provide in addition to the inherent benefits of undergoing treatment.

ALTERNATIVE OF NO TREATMENT: This is always an alternative and must be discussed along with the potential sequellae associated with this choice.

INFORMED CONSENT IS ONGOING IN NATURE: As the patient’s clinical picture changes so does the need for a discussion of these findings and their potential effect on the patient.

How you go about obtaining a patient’s informed consent should be memorialized in some fashion such as a patient’s/parent’s signature, noting in detail what was said on the patient’s chart, keeping copies of information given to the patient, etc. In addition, the patient should be given the opportunity to ask, and have answered, all of their questions. 
NOTE: The following is a checklist that the person obtaining the informed consent from the patient/parent should use in determining the potential negative sequellae for each individual case. The items checked off should be discussed, and this discussion documented in some fashion.
CHECKLIST FOR INFORMED CONSENT REGARDING RISKS, COMPROMISES AND LIMITATIONS

[] HYGIENE RELATED PROBLEMS
- caries and/or decalcifications

[] ROOT RESORPTION
- does the root structure or intended mechanics predispose a greater risk of this occurring
- is there risk to an adjacent tooth i.e. an impacted canine and its effect on the root of the lateral

[] PERIODONTAL COMPLICATIONS
- will the intended mechanics heighten the potential for this sequellae
- is the patient’s existing periodontal condition compromised or predisposing to negative sequellae

[] REBOUND AND/OR RELAPSE VS. NORMAL TOOTH MOVEMENT
- the natural phenomenon for teeth to respond to environmental factors should be discussed

[] TMJ/MPD
- the transitory and multifactoral nature of this potential problem should be discussed particularly if there are pre-treatment symptoms

[] ENDODONTIC PROBLEMS
- this should be discussed if there is a history of trauma, deep decay and/or restorations, or teeth that are out of or will be moved through the buccal plate

[] ALLERGIES
- acrylic appliances, latex sensitivity, nickel

[] CERAMIC BRACKETS
- if using a chemical bond enhancing agent the patient should be informed regarding debonding fracture
- in addition, attrition and/or cusp fracture of the opposing dentition should be noted

[] REMOVABLE APPLIANCES
- ingestion, aspiration, and additional charges for lost or broken appliances

[] HEADGEAR
- the potential for soft tissue and/or ocular injury

[] ORAL SURGERY
- inability to close extraction spaces or osteotomy sites
- uncertainty related to the exposure of impacted teeth

[] GROWTH
- excessive, unanticipated, or insufficient growth can occur during or after treatment
[] INSUFFICIENT COOPERATION
- can extend the length of treatment
- can effect the amount of correction achieved
- if related to hygiene see above

[] SECONDARY RESTORATIVE TREATMENT NEEDED
- will the patient need implants, prosthetics, permanent splinting, etc.
- discuss that the fee for these secondary procedures is not part of the orthodontic fee charged

[] SKELETAL COMPONENT WITH ASSOCIATED DENTAL COMPENSATIONS
- if there is a skeletal component and camouflage therapy is recommended, discuss the anatomical limitations and the associated dental compensations that will remain at the end of treatment

[] RETENTION
- long term, lifetime, fixed or removable
- discuss with the patient that active treatment is completed and that the retention phase of treatment will last for “x” period of time
- discuss the prognosis for long term stability

[] LIMITED TREATMENT
- discuss the specific goals and objectives
- stop treatment when they have been met
- if a second phase of treatment will be necessary discuss that and that there will be a separate fee for that service

[] TOOTH SIZE/ARCH LENGTH DISCREPANCIES
- discuss the effect on the completed occlusal scheme
- discuss post treatment spacing
- discuss the need for post treatment restorative dentistry and that these fees are not part of the patient’s orthodontic fee

[] CONTINUED DELETERIOUS HABITS
- if habits persist or develop post treatment, discuss the negative effect on stability

[] TIMING OF TREATMENT AND RELATED PROBLEMS
- discuss the option of 2 phases of treatment verses 1 phase
- be sure to include the fiscal, temporal, and psychosocial aspects of each

[] PRIVACY ISSUES
- discuss that your doctor may consult with other doctors about patient’s treatment and that patient’s records will be transmitted over the internet
- discuss any other ways in which the patients records will be used and subject to disclosure

This form can either be used as a guide for the consultation visit or can be modified from checklist style to paragraph style to accommodate a patient’s signature on the bottom or their initials next to each item, if desired.
IMPORTANT INFORMATION ABOUT YOUR ORTHODONTIC TREATMENT

Orthodontic treatment like other forms of medical treatment offers tremendous benefits. Likewise, there are occasional problems that patients sometimes encounter. Most of the time these problems are usually not severe enough to contraindicate treatment, they should be considered by you before deciding to undergo orthodontic treatment. Please indicate your understanding of these facts by placing your initials in each box below.

**DISCOMFORT:** As your teeth move they may become slightly loose and this may be uncomfortable. Patients usually get used to this within a short period of time and once the braces are removed the teeth tighten up again. If you are having any pain – call your doctor, let us help. Also, your teeth may hurt for a day or two after an adjustment. This is normal and simple over-the-counter painkillers will be helpful.

**ORAL HYGIENE:** Properly brushing your teeth is a MUST. If proper oral hygiene is not maintained, permanent marks and scarring of the teeth can result. Poor brushing can also lead to cavities as well as to gum disease. In severe cases, treatment may have to stopped before it is completed or teeth may be lost. **You are responsible for continuing to see your regular dentist for check-ups and cleanings at least twice a year. Please don’t expect us to replace your general dentist.**

**ROOT DAMAGE:** During tooth movement is not unusual for the tips of the roots of your teeth to shrink slightly. This is not significant unless it becomes severe. This may also occur as teeth are developing and erupting into the mouth. We will monitor your teeth throughout treatment and alert you to any significant changes.

**TMJ / MPD:** Sometimes during treatment, a patient’s jaw joint will become inflamed. On rare occasions it becomes severe enough to require additional treatment by your dentist or other specialists. If you are having any problems – speak with your doctor.

**RELAPSE:** Change is everywhere and orthodontics is not immune. In children there are rapid periods of growth that cause dramatic changes in the size or jaw position of one’s jaws. In adults, this change is merely the result of aging. Either way, orthodontic results are not 100% stable and some movement is normal. We can’t control genetics, habits, growth, the size of your teeth, and other factors that can cause teeth to shift slightly after treatment is completed. When treatment is complete, we will provide you with retainers which you will have to wear to help minimize this movement but nothing lasts forever, including straight teeth.

**DAMAGE FROM APPLIANCES:** Certain types of braces carry some associated risks. Ceramic braces may cause slight damage to the teeth they are attached to as well to the teeth they bite against. Patients have occasionally reported allergic reactions to the acrylic in their removable appliances, the latex used in the rubber bands, while others have had similar reactions to some of the metals used in traditional braces. Finally, there have been rare instances where a patient has suffered an eye injury because of improper headgear (night brace) use.
TREATMENT DECISIONS: Occasionally, patients have skeletal problems but are unwilling to undergo facial surgery to correct them. When this happens, certain compromises in the result have to be accepted. Similar compromises result when one chooses to only treat a limited aspect of a more involved problem. Braces are also often undertaken in preparation for other dental procedures that may not be followed through on. Finally, prolonging treatment can sometimes result in not being able to achieve the best correction. Decisions like these can cause a less than ideal result.

OTHER DENTAL TREATMENT: On rare occasions the nerve of a tooth undergoing orthodontic treatment will die and require a root canal. In addition, the inability to fully close an extraction space, or the loss of a tooth undergoing surgical exposure, are also rare side effects associated with those treatments.

ANATOMIC LIMITATIONS: Occasionally, a patient’s teeth are not the correct size or shape for the size of the patient’s jaw. This may result in slight spacing or the need for bonding or caps at the end of treatment. Also teeth can only be moved so far and if the jaws are too big or too small facial surgery may be necessary.

PATIENT COOPERATION: Patient cooperation such as following your doctor’s instructions and keeping regularly scheduled appointments is absolutely necessary for optimal results to be achieved. If not, treatment time may have to be extended. Also, if patients continue to engage in harmful oral habits such as thumb sucking or grinding your teeth, the stability of the finished result may be compromised.

PATIENT PRIVACY: Like all healthcare services, my doctor may have to consult with other healthcare professionals concerning my treatment. This is usually done via Internet transmission. Permission is hereby granted to exchange medical and dental information about me / my child only as it relates to providing and paying for orthodontic treatment. In addition, I give permission for photos, x-rays, models and clinically relevant data of me / my child to be used in scientific publications and/or presentations and for no other purpose.

OTHER:

My orthodontic treatment has been thoroughly discussed with me. I have had the opportunity to ask questions about my proposed treatment and I understand the potential benefits and risks as noted above. I also understand that during treatment, circumstances may arise requiring either a discontinuation of or a change from the original treatment plan. If either of these occurs, it may result in adjustments to the cost of treatment. Lastly, I understand that the fee presented to me is only for orthodontic treatment and if other dental treatment is necessary, there will be additional fees charged for those services.

Signature of patient or parent if patient is a minor     Date

_________________ / ____________________
Signature and printed name of Witness
CONSENT FOR USE OF
TEMPORARY ANCHORAGE DEVICE (TAD)

Your doctor has recommended the use of a temporary anchorage device (TAD) also known as a micro screw or mini screw. This device is to aid your doctor in his ability to move certain teeth while not affecting the position of other teeth. While this is not the only method to achieve the desired result, it is a very effective and efficient means of doing so, but it does carry some risks of which you should be aware. The following paragraphs are designed to inform you of the known risks associated with this procedure thereby providing you with sufficient information to make an informed decision about accepting this form of treatment.

PLEASE PLACE YOUR INITIALS IN THE BOX NEXT TO EACH PARAGRAPH INDICATING THAT YOU HAVE READ AND UNDERSTOOD WHAT IT SAYS.

ALTERNATIVE TYPES OF TREATMENT
The TAD procedure has been explained to me and I understand that it is one of several alternative means to achieve a desired result. The other anchorage alternatives along with any compromises and limitations associated with them has been explained to me.

PAIN AND / OR DISCOMFORT
Any surgical procedure carries the risk of some degree of pain or discomfort. Inserting a TAD is no different, however any pain or discomfort can usually be addressed through the use of simple over the counter pain medication. There is usually no problem with returning to work or school the next day. If you are still experiencing significant discomfort after 48 hours, call your doctor immediately.

INJURY TO THE ROOTS OF TEETH
As TAD’s are placed in close proximity to the roots of your teeth, the implants may occasionally come into contact with them. While this may cause minor damage to the roots, in most cases this type of injury is not clinically significant. On rare occasions a root canal procedure may be required. It is also remotely possible for TAD placement to result in loss of a tooth.

BLEEDING AND / OR POST OPERATIVE INFECTIONS
All surgical procedures carry the risk of excessive bleeding or post operative infection. While the potential for excessive bleeding is extremely rare, occasionally a minor infection may result from the placement of a TAD. Should this occur, routine antibiotic therapy may be necessary.

INJURY TO THE NERVES
Placing a TAD may injure a nerve leading to a tooth or to the jaw. The resulting tingling and / or numbness is usually temporary but on rare occasions it may become permanent.

PERFORATION OF THE SINUS
Occasionally, a portion of the TAD may perforate the sinus. Usually this does not present a problem. On rare occasions, if a perforation does not heal properly, a second surgical procedure by another doctor may be necessary to repair the sinus.
REMOVAL OF IMPLANT / CHANGE OF TREATMENT PLAN

All TAD’s need to be removed after your treatment is completed. However, if one or more TAD’s should have to be removed early because of any of the above noted factors, even at the time they are placed, your treatment plan may have to be changed. It may be as simple as using another form of anchorage, having to extract teeth, or, in rare situations, jaw surgery may be required. Your doctor will discuss these options with you if the need arises.

PATIENT COOPERATION

Patient cooperation such as following your doctor’s instructions regarding the wearing and changing of any elastics, as well as following precisely any oral hygiene instructions, is critically important to minimize negative occurrences and maximize the results of therapy.

OTHER FEES

I understand that the fee presented to me is only for orthodontic treatment including the placement of the TAD’s. If other dental or surgical treatment is necessary, there will be additional fees charged for those services by the doctors who provide those services.

PATIENT PRIVACY

Like all healthcare services, my doctor may have to consult with other healthcare professionals concerning my treatment. Permission is hereby granted to exchange medical and dental information about me / my child only as it relates to providing and paying for my treatment. In addition, I give permission for photos, x-rays, models and clinically relevant data of me / my child to be used in scientific publications and/or presentations and for no other purpose.

GUARANTEES

I understand that perfect results are not guaranteed in the delivery of oral health care services and that the use of TAD’s as part of my treatment will neither guarantee a better result nor faster treatment.

MY UNDERSTANDING

I certify that I speak, read, and write English or, have had the contents of this form translated to me in my native language. I fully understand the benefits and risks associated with using TAD’s and voluntarily accept them.

Printed name of patient or parent (if a minor)       Signature of patient or parent (if a minor)       Date

Printed name of witness               Signature of witness                             Date
INFORMED CONSENT REGARDING INTERPROXIMAL REDUCTION

You have been advised that as part of your orthodontic treatment plan, it is necessary to remove some enamel from the sides of some of your teeth. This procedure goes by various names. It is often referred to as interproximal reduction, reproximation, stripping, IPR, and enamelplasty.

WHAT IS INTERPROXIMAL REDUCTION (IPR)?

Essentially, what the procedure involves is removing small amounts of enamel from the sides of one or more teeth in an effort to make a tooth's dimension smaller. This is most often done to create additional space to resolve mild to moderate crowding as well as to recreate normal anatomy for a tooth that was slightly malformed. Other alternative methods to create this space would be to either extract permanent teeth or to flare out the teeth and expand the dental arch form, each one of which has its own potential negative consequences.

HOW IS IPR PERFORMED?

There are two basic approaches to removing enamel from the sides of teeth. The first is to take "sandpaper" like strips and rub them back and forth along the sides of the teeth removing a small amount of the outer layer of enamel. The other most common way is to use rotary instruments (dental drills) with either very thin discs or very small burrs to file down the sides of the teeth.

WHAT ARE THE RISKS OF THIS PROCEDURE?

For the most part, the risks are very small. Occasionally however, the following occurrences sometimes happen:
- small step like projections can occur along the side of a tooth,
- cavities may occur in areas where the tooth has been filed down,
- the affected tooth may become sensitive to hot or cold stimulation,
- the gum tissue around the tooth may become cut, inflamed or swollen,
- the shape of the affected teeth may be different from the adjacent teeth, and
- the patient's gums, lips or tongue may be cut during the procedure.

While the above occurrences do sometimes occur, when they do most of the time they are of such a minor nature that there are no long lasting negative effects. In very rare cases, IPR may lead to the nerve of a tooth being permanently injured.

DO I HAVE TO HAVE THIS PROCEDURE PERFORMED?

No you do not, but as previously mention, the only other alternatives would be to extract permanent teeth or to place the teeth in positions that might be very unstable.

CONSENT

I have been informed that [ ] I [ ] my child requires IPR and I acknowledge that I am aware of what the procedure is, what it entails, and the potential risks associated with the procedure. I have also been informed about other alternatives to IPR. I have had the opportunity to have all of my questions concerning IPR asked and answered.

________________________  ________________
patient, parent, or legal guardian          date
CONSENT FOR LIMITED TREATMENT

Orthodontics provides you with the opportunity to improve certain aspects of not only how your mouth functions but also, how your smile looks. Generally speaking when patients go to an orthodontist for a consultation, they are presented with the best treatment plan that addresses all of the patient's complaints as well as the doctor's concerns. Occasionally however, orthodontists find that their patients desire to only have limited treatment performed.

For example, let's say that you have some crooked or crowded upper front teeth. You also have an overbite with your top teeth sticking out a little bit past your lower front teeth. Your doctor may want to fix the overbite as well as the crowding in one of a number of different ways. You on the other hand, don't care about the overbite and merely want your front teeth aligned to improve your smile.

Enter the world of limited treatment. If you decide you only want to correct part of your total orthodontic problem, that's fine; however you must be aware of certain facts.

1- Deciding to accept limited treatment means just that. Your doctor will only address those concerns. Other orthodontic problems will not be corrected.

2- If, after correcting what you were concerned about, you now choose to have the remaining problems addressed, an additional fee will be charged and additional time in braces will be necessary.

3- We will not offer a patient the limited treatment option if the patient's periodontal support cannot withstand the rigors of orthodontic tooth movement OR, if in our opinion, limited treatment will cause other harm to the supporting hard and/or soft tissues in your mouth.

4- In some cases the ideal result cannot be achieved because we are not treating all of the teeth. This is a limitation YOU, the patient, must accept.

5- Limited treatment results must be maintained after treatment is completed in the same way that full orthodontic therapy must be retained. Your doctor will explain the necessary retention protocol to follow.

6- Over time, there may be detrimental effects from not having comprehensive or full treatment performed. Remember this would have happened anyway had you had no treatment; and it may still occur even though you had limited treatment, as the cause may have been the problem(s) you chose not to treat.

I, ______________________________, have had the option of limited treatment explained to me and understand that only a portion of my orthodontic problem(s) will be addressed. The choice to accept limited treatment is mine alone and I am aware of the limited benefits to be achieved. I understand and release Dr. ___________________________ for any negative occurrence I may encounter as a result of allowing only limited treatment to be performed.

___________________________  ________________  
signature of patient / parent     date

___________________________  ________________
signature of witness      date
CONSENT FOR USE OF TEMPORARY ANCHORAGE DEVICE (TAD)

Your doctor has recommended the use of a temporary anchorage device (TAD) also known as a micro screw, mini screw, or micro implant. This device is to aid your doctor in his ability to move certain teeth while not affecting the position of other teeth. While this is not the only method to achieve the desired result, it is a very effective and efficient means of doing so, but it does carry some risks of which you should be aware. The following paragraphs are designed to inform you of the known risks associated with this procedure thereby providing you with sufficient information to make an informed decision about accepting this form of treatment.

PLEASE PLACE YOUR INITIALS IN THE BOX NEXT TO EACH PARAGRAPH INDICATING THAT YOU HAVE READ AND UNDERSTOOD WHAT IT SAYS.

ALTERNATIVE TYPES OF TREATMENT
The TAD procedure has been explained to me and I understand that it is one of several alternative means to achieve a desired result. The other anchorage alternatives along with any compromises and limitations associated with them has been explained to me. 

PAIN AND / OR DISCOMFORT
Any surgical procedure carries the risk of some degree of pain or discomfort. Inserting a TAD is no different, however any pain or discomfort can usually be addressed through the use of simple over the counter pain medication. There is usually no problem with returning to work or school the next day. If you are still experiencing significant discomfort after 48 hours, call your doctor immediately.

INJURY TO THE ROOTS OF TEETH
As TAD’s are placed in close proximity to the roots of your teeth, the implants may occasionally come into contact with them. While this may cause minor damage to the roots, in most cases this type of injury is not clinically significant. On rare occasions a root canal procedure may be required. It is also remotely possible for TAD placement to result in loss of a tooth.

BLEEDING AND / OR POST OPERATIVE INFECTIONS
All surgical procedures carry the risk of excessive bleeding or post operative infection. While the potential for excessive bleeding is extremely rare, occasionally a minor infection may result from the placement of a TAD. Should this occur, routine antibiotic therapy may be necessary.

INJURY TO THE NERVES
Placing a TAD may injure a nerve leading to a tooth or to the jaw. The resulting tingling and / or numbness is usually temporary but on rare occasions it may become permanent.

PERFORATION OF THE SINUS
Occasionally, a portion of the TAD may perforate the sinus. Usually this does not present a problem. On rare occasions, if a perforation does not heal properly, a second surgical procedure by another doctor may be necessary to repair the sinus.
REMOVAL OF IMPLANT / CHANGE OF TREATMENT PLAN

All TAD's need to be removed after your treatment is completed. However, if one or more TAD's should have to be removed early because of any of the above noted factors, even at the time they are placed, your treatment plan may have to be changed. It may be as simple as using another form of anchorage, having to extract teeth, or, in rare situations, jaw surgery may be required. Your doctor will discuss these options with you if the need arises.

PATIENT COOPERATION

Patient cooperation such as following your doctor’s instructions regarding the wearing and changing of any elastics, as well as following precisely any oral hygiene instructions, is critically important to minimize negative occurrences and maximize the results of therapy. Smoking is extremely harmful, please abstain.

OTHER FEES

I understand that the fee presented to me is only for orthodontic treatment including the placement of the TAD’s. If other dental or surgical treatment is necessary, there will be additional fees charged for those services by the doctors who provide those services.

PATIENT PRIVACY

Like all healthcare services, my doctor may have to consult with other healthcare professionals concerning my treatment. Permission is hereby granted to exchange medical and dental information about me / my child only as it relates to providing and paying for my treatment. In addition, I give permission for photos, x-rays, models and clinically relevant data of me / my child to be used in scientific publications and/or presentations and for no other purpose.

GUARANTEES

I understand that perfect results are not guaranteed in the delivery of oral health care services and that the use of TAD’s as part of my treatment will neither guarantee a better result nor faster treatment.

MY UNDERSTANDING

I certify that I speak, read, and write English or, have had the contents of this form translated to me in my native language. I fully understand the benefits and risks associated with using TAD’s and voluntarily accept them.

_________________________       _________________________       _____________
Printed name of patient or parent (if a minor)       Signature of patient or parent (if a minor)            Date

_________________________       _________________________       _____________
Printed name of witness               Signature of witness                             Date
**FEDERAL TRUTH IN LENDING STATEMENT**

for professional services rendered

Patient: ______________________________________________________________

Address: ______________________________________________________________

Financially Responsible Party / Relationship: __________________________________

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<tbody>
<tr>
<td>1</td>
<td>Professional Fee for Services Rendered</td>
<td>$ __________</td>
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<tr>
<td>2</td>
<td>Less Down Payment</td>
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<tr>
<td>3</td>
<td>Balance Due</td>
<td>$ __________</td>
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<tr>
<td>4</td>
<td>FINANCE CHARGE</td>
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<tr>
<td>5</td>
<td>ANNUAL PERCENTAGE RATE</td>
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<tr>
<td>6</td>
<td>Total Fee Remaining (3+4+5 above)</td>
<td>$ __________</td>
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"Total Fee Remaining" (6 above) is payable to Dr. ______________________________ at the above address in ___ monthly installments of $ ______, the first installment being payable on 200 __, and all subsequent installments are due on the same day of each consecutive month until paid in full. **Although we accept payments from 3rd party carriers, you are ultimately responsible for the total fee should benefits be denied to you for any reason.**

**MISSED APPOINTMENTS**

- Please note that the time of your appointment was specifically reserved for you.
- **Instances of broken appointments without 24 hours notice WILL result in additional charges depending on the length of appointment missed.**

**SERVICE CHARGES**

- Please note our office policy regarding the following service charges.
- **There will be a service charge of $ _____ if payment is not received within 2 weeks of the date due.**
- **There will also be an added service charge of $ _____ for handling any returned checks.**
- **All costs incurred for the collection of past due accounts, including reasonable attorney's fees will be passed on to you.**
- **An additional fee will be for repeated or excessive breakage, and for loss of appliances when either inordinately extends treatment time estimates.**

**FINANCIAL CONSENT**

I agree to be fully responsible for the total payment of all fees for professional services rendered by Dr. ______________________________ I have read, understood and freely agree to the terms and conditions set forth herein. I have also received a copy of this agreement.

__________  ______________________________________________________
DATE    FINANCIALLY RESPONSIBLE PARTY
GENERAL RELEASE

This agreement between [_____ (Parent)_____] as legal guardian for _____(Patient's Name)____] or [_____ (Patient's Name)____] and _____(Dr's. Name)____ is being executed to resolve a disputed claim regarding orthodontic services rendered. It does not imply nor constitute an admission of liability on the part of _____(Dr's. Name)____, or his/her employees or professional contractors.

In consideration of $_____ paid by _____(Dr's. Name)____ to _____(Patient's Name)____: (Patient's Name)____, his/her heirs, executors, administrators, assigns, and/or guardians hereby fully releases _____(Dr's. Name)____, his/her employees, agents, his/her professional corporation (if you use an independent contractor include that name here) from all claims and causes of action stemming from any injury suffered, or sustained presently, or in the future as a result of the orthodontic treatment rendered between (dates of treatment) .

I _____(Patient's Name)_____ have read and fully comprehend all of the foregoing agreement, I also understand the rights I am waiving, I have had the opportunity to consult with an attorney, and freely agree to the terms and conditions of this letter.

_____(Patient or Legal Guardian)________________________ (Doctor) *________________________
________________________ Signature________________________ Signature

________________________ (Witness)________________________
________________________ Signature________________________

*If Dr. is P.C. list both names.
NON-DISPARAGEMENT CONTRACT

In exchange for a reduction for a fee reduction of $__________ from the usual and customary fee charged by Dr. Goode for his orthodontic services, I am voluntarily agreeing to be bound by the terms as specified below.

In an effort to ensure that all public feedback or commentary regarding the orthodontic services provided by this office is both fair and honest, and to prevent the publishing of libelous content in any form, you agree that you will not, nor will you cause or cooperate with others to, publicly criticize, ridicule, disparage, or defame Dr Straightensem Goode, his professional corporation, employees, contractors, and associates, with or through any written or oral statements or images including, but not limited to, any statements made via Web sites, blogs, postings to the Internet, or e-mails, whether or not they are made in your name, anonymously, or with a pseudonym. You also agree to provide full cooperation and assistance in aiding this office or its representatives to investigate such statements if we reasonably believe that you are the source of the statements. The foregoing does not apply to statutorily privileged statements made to governmental or law-enforcement agencies, nor does it apply to statements made or testimony given during the course of any duly filed litigation in courts of competent jurisdiction between you and this office.

If you violate this clause, as determined by Dr Goode in his sole discretion, you will be given a 72-hour opportunity to retract the content in question. If the content remains, in whole or in part, you will immediately be indebted to Dr Goode for the amount of $100,000 for liquidated damages. Since actual damages would be difficult to determine as a result the disparagement, this agreed-upon amount represents a fair and reasonable estimate by both parties of the financial loss that negative posts will cause. This amount was determined to be a reasonable estimate by assuming that 20 patients during a year, at an average fee of $5000, will not seek treatment from Dr Goode as a result of the disparagement. This agreed-to amount is not deemed to be punitive but, rather, a fair representation of future damages. In addition, if you decide to litigate this matter and if you are found to be liable for having breached the nondisclosure agreement, you also agree to pay all of Dr Goode's reasonable attorney's fees as well as court costs relating to the litigation. If these charges remain unpaid for 30 calendar days from the billing date, your unpaid balance will be subject to collection and all other legal remedies available. In addition, the debt will be reported to all appropriate consumer credit reporting agencies until paid. Finally, the parties agree and acknowledge that this provision is a material term of the doctor-patient contract, the absence of which would have resulted in Dr. Goode refusing to render orthodontic treatment to you / your child.

________________________  _______________________
PATIENT OR PATIENT'S PARENT/GUARDIAN        DATE

________________________
DOCTOR OR DOCTOR'S REPRESENTATIVE