

Lake Travis Oral Surgery

Jeff Alford, DDS

**Consent and Release for Photograph for Performance of Diagnostic Cone Beam 3-D Imaging**

You have the right to be informed about your condition and the recommended treatment plan so you may make an informed decision after knowing the risks. This disclosure is meant to properly inform you so you may give or withhold your consent. The i-CAT cone beam CT provides imaging of the maxillofacial area producing the most complete anatomical information on a patient's mouth, face, jaw, and soft tissue. The purpose of your scan is for oral and maxillofacial diagnostic purposes only.

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS PLEASE ASK BEFORE INITIALING.

\_\_\_\_\_ **PROCEDURE-** I consent to Lake Travis Oral Surgery to perform the Cone 3-D tomography.

\_\_\_\_\_ **RISK-** I understand there are certain inherent and potential risks in the use of radiation, that in this specific instance such risks have been minimized by the use of a highly collimated x-rays beam.

\_\_\_\_\_ **PREGNANT WOMEN-** If you are a woman, you will be questioned regarding pregnancy. If you are pregnant, or you are unsure if you are pregnant, you will be given the option not to have the scan.

\_\_\_\_\_ **RELEASE-** I authorize Dr. Alford and his employees to release any information and records concerning my treatment as may be necessary to process insurance claims or payment for the care and treatment provided or to other healthcare professionals.

\_\_\_\_\_ **REFUSAL OF PROCEDURE-** Your decision to undergo this scan is voluntary. You may refuse to participate or discontinue participation at any time. However, you should be aware this procedure has been recommended to provide information that is not clinically available. Refusal of the procedure will result in lack of information, which could result in a less than optimum treatment for your condition.

\_\_\_\_\_ **INTERPRETATION-** Your scan will be read and interpreted by our doctor. However, you may request that your scan be reviewed and interpreted by a radiologist. You will be responsible for any separate fees charged by the radiologist. \_\_\_\_\_ Please initial here if you would like a radiologist to read your scan.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

If not the patient, relationship to the patient: \_\_\_\_\_

Representative of Lake Travis Oral Surgery: \_\_\_\_\_