Great Lakes
— PROSTHODONTICS

24600 Detroit Road, Suite 200 · Westlake, Ohio 44145
(440) 808-9809 · info@glppros.com · glppros.com
Anthony Deliberato, DDS · Christian Loo, DDS · Eric Guirguis, DDS, MSD

HIPAA Acknowledgement & Consent for Treatment

Complete on screen and save, then print the last page to sign by hand.
A typed name is not a signature — the signed page must be returned to the office.

PATIENT NAME _____ DATE OF BIRTH _____ TODAY'S DATE _____

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

Great Lakes Prosthodontics maintains a Notice of Privacy Practices describing how your protected health information may be used and disclosed, and how you may obtain access to that information. A copy is available at our office on request. By signing below, you acknowledge that you have been offered a copy of that notice.

☐ I acknowledge that I was offered a copy of the Notice of Privacy Practices ☐ I would like a printed copy

PERMISSION TO SHARE INFORMATION WITH OTHERS

We will not discuss your care with anyone you have not named here, except as permitted by law. You may change this list at any time in writing.

NAME _____ RELATIONSHIP _____ PHONE _____

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You may leave a detailed message: ☐ On my mobile voicemail ☐ On my home voicemail ☐ With the people named above ☐ By email ☐ Please leave name and callback only

You may send appointment reminders by: ☐ Text message ☐ Email ☐ Phone call ☐ Post

CONSENT FOR EXAMINATION AND TREATMENT

I authorise Dr. Anthony Deliberato and the doctors and clinical staff of Great Lakes Prosthodontics to perform the examination, diagnostic imaging, and treatment procedures necessary or advisable to diagnose and treat my dental condition. I understand that:

- Dentistry is not an exact science and no guarantee has been made to me about the result of examination or treatment.
- The treatment plan and fees will be explained to me before treatment begins, and may need to change if conditions are found that were not apparent at the outset.
- Every procedure carries risks, which will be explained to me before I consent to that procedure. These may include discomfort, swelling, bruising, infection, bleeding, numbness that is usually temporary but may be lasting, injury to adjacent teeth or restorations, jaw joint symptoms, and — with implants — the possibility that an implant does not integrate and must be removed or replaced.
- Local anaesthetic will usually be used, and I have disclosed any allergy or prior reaction on my medical history form.
- I may ask questions at any time, and I may withdraw my consent before or during treatment.

RADIOGRAPHS AND PHOTOGRAPHS

I consent to dental radiographs, including 3D cone-beam imaging, and to intraoral scanning as needed for diagnosis and treatment planning. Clinical photographs may be taken as part of my record.

My photographs may also be used, without my name, for: ☐ Teaching and lectures ☐ The practice website ☐ No — records only

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges whether or not they are covered by insurance, and that the practice will submit claims on my behalf as a courtesy. I have been given the opportunity to discuss fees and payment options.

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SIGNATURE

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE

PRINT NAME

RELATIONSHIP IF SIGNING FOR THE PATIENT

WITNESS — OFFICE USE

Please return all completed forms to the front desk, or bring them with you to your first appointment. If you would prefer to complete them here, arrive about fifteen minutes early and we will help. Questions? Call **(440) 808-9809**.