INFORMED CONSENT FOR TELEDENTISTY

--- *PINCOFSKI ORTHODONTICS* ---

I, _____ hereby authorize and request Dr. Susan Pincofski to provide to me dental professional services using electronic and/or digital communications, or teledentistry.

I acknowledge the following:

1.) The potential for breach of confidentiality, or inadvertent access, of protected health information using electronic and digital communication in the provision of care
2.) The potential disruption of electronic and digital communication in the use of teledentistry

I permit Dr. Pincofski to use teledentistry services to provide for **an orthodontic consultation.**

I acknowledge that it is Dr. Pincofski's role to determine whether the condition being diagnosed or treated is appropriate for a teledentistry encounter.

Risks, benefits and alternatives: The benefits of teledentistry include having access to a dentist and additional dental information without having to travel to a dental office or clinic. A potential risk of teledentistry is that a face-to-face consultation with a dentist may still be necessary after the teledentistry appointment. This could be because of my specific medical or dental condition or for other reasons. Recommendations will be made to me about my future dental care after the teledentistry consultation. These could include recommendations about whether or not to see a dentist, specialist or oral surgeon. A visit to the orthodontist office may be needed in the future even if it is not recommended now. The recommendations may change if more information about my dental needs becomes known. The alternative to teledentistry consultation is a face-to-face with a dentist.

I may choose bit to participate in a teledentistry consultation at any time before and/or during the consultation. If I decide not to participate, it will not affect my right to future care or treatment. I have the option to seek dental consultation or treatment in a dental office at any time before or after the teledentistry consultation.

Dr. Pincofski will discuss with me the information provided above. I will have an opportunity to ask questions about this information I acknowledge that no guarantee or assurance has been made regarding any treatment.

Signed By _____ Date_____
(Patient)

Signed By _____ Date_____
(Doctor)

Signed By _____ Date_____
(Witness)