SWATI AGARWAL DDS

CONSENT TO PARTICIPATE IN A TELEDENTISTRY SYSTEM

PATIENT NAME _____ PATIENT DATE OF BIRTH _____

PURPOSE: The purpose of this form is to obtain your permission for you to participate in a system of dental care called "teledentistry". You will be offered an exam and limited dental treatment in a virtual location that may not be a dental office or clinic.

Dental Professional Name: Swati Agarwal, DDS

Dentist Address: 500 Sutter Street, Suite 615, San Francisco, CA 94102

Dentist Telephone: 415-362-5315

The teledentistry system allows a dentist to view your records through the internet. The dentist will then make recommendations about your treatment. The dentist may not see you in person.

1. **WHAT IS A TELEDENTISTRY CONSULTATION?** Teledentistry is a way to provide care for people who do not or cannot go to a dentist's office. Teledentistry uses electronic dental records such as electronic versions of X-rays, photographs, recordings of the condition of your teeth, health and other information**.** These records are reviewed at a later time. These records are known as "store and forward" records. The goal of the teledentistry system is to have the dentist create recommendations for you for dental care.

2. **WHAT HAPPENS DURING TELEDENTISTRY CONSULTATION?** The dentist will examine your mouth visually and collect dental records. The doctor will record what they see. Your medical and dental history and personal health information may be discussed with other health professionals. These discussions will occur through phone calls or "store and forward" technology. A teledentistry consultation may require more than one visit.

3. **WHAT ARE THE 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. Some of the procedures that you may receive include a limited examination and check up. A potential risk of teledentistry is that a face-to-face consultation with a dentist may still be necessary after a teledentistry appointment. This could be because of your specific medical or dental condition or for other reasons. Recommendations will be made to you about your future dental care after the teledentistry consultation. These could include recommendations about whether or not to see a dentist in a dental office or dental clinic. A visit to a dental office may be needed in the future, even if it is not recommended now. The recommendations may change if more information about your dental needs becomes known. The alternative to teledentistry is a face-to-face visit with a dentist.

The practice of dentistry is not an exact science. Therefore, any specific results cannot be guaranteed.

4. **CONFIDENTIALITY**. Current federal and California laws about confidentiality apply to the information used or disclosed during your teledentistry consultation. You will be provided with a separate document, which describes how your private information will be handled. This is known as the "Notice of Privacy Practices."

5. **RIGHTS.** You may choose not to participate in a teledentistry consultation at any time before and/or during the consultation If you decide not to participate, it will not affect your right to future treatment You have the option to seek dental consultation or treatment in a dental office at any time before or after the teledentistry consultation.

My dental care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this and all of my questions have been answered. I agree to have records, including electronic versions of X-rays, photographs, charting of conditions and health and other information, collected from me and shared and used in this study as described in this consent form and in the "Notice of Privacy Practices" I have received I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment I have requested and authorized.

_____ _____

Signature of Patient or Signature of Patient's Parent/ Legal Guardian

_____ _____

Name of Patient (print) or Name of Patient's Parent/ Legal Guardian (print)

_____ _____

Name of Interpreter/ID# (print) Signature of Interpreter

_____ _____

Signature of Witness Relationship of Witness to Patient
(required if patient is unable to sign)

_____

Name of Witness (print)

_____

Date of Signing

REFUSAL: I refuse to participate in a teledentistry consultation as described above

_____ _____

Signature Date of Signature