Smile Dental Home Care Services

GENERAL INFORMED CONSENT FOR CARE / TREATMENT / PROCEDURE

Patient Name.....UHID#: .....

I..... Age ..... Resident of .....

have read/or been explained this consent from in ..... (name of language) which I fully understand

I give my consent and authorize Smile Dental Home Care Services (SDHCS) staff to screen, evaluate and provide relevant care as deemed necessary by my treating doctor/health care team.

I declare that, I have & will inform the SDHCS staff of my medical history including previous illnesses, allergies. drug reaction(s), surgical procedure, relevant medical family history and all other facts relevant to my treatment I shall not hold Smile Dental Home Care Services/Staff responsible for any consequences which may arise due to non-disclosure of relevant information on my part.

I have been explained that during the course of my core/treatment/procedure, may be administered medications orally, intravenously or by any other route as required. I may also have to undergo any one or more of these procedures like IV Cannulation IV Infusion/ drawing of samples for laboratory services and interventions like bladder wash / Nebulization / tube irrigation / wound care and dressings/ suctioning / tracheotomy care / urinary catheterization etc i have been adequately explained about the risks, benefits and complications associated with these procedures and drug administration which could be minor/major/severe reactions with rare serious/fatal consequences.

During the course of care / treatment / procedure, I may be advised to undertake rahabilitation services like physiotherapy, speech and language therapy etc which may include an individualized exercise prescription, and various forms of manual therapy techniques such as mobilization, manipulation, soft tissue release and stretches Treatments may also include use of electrotherapeutic modalities for speech and language therapy, treatment will be provided based on an individualized care plan wherein active participation of the caregivers will be involved in carrying out the recommended interventional activities.

I agree to observing, photography (still/video/televising) of the procedure (including relevant portions of my body) including my diagnosis/reports (pathology, radiology, etc), for academic/medical/medico-legal purposes or scientific publications provided my identity is not revealed by such acts.

I understand that Smile Dental Home Care Services will take due care of me/ my patient but, there is always a possibility of an unexpected complication(s) which may necessitate prolonged care. In such cases, procedure different from those contemplated or other intervention(s) may sometimes be needed. I understand that in case i of some unexpected event occurring during the course of my care I may be suggested a transfer to another hospital/health care organization, as considered appropriate by my treating doctor/Health care team.

I also understand that as my treatment is provided at home, there may be limitations to the scope of services. accessibility and availability of resources and handling of medical emergencies, if they may arise.

I have been explained about the proposed care plan intended benefits expected result(s), possible outcome(s) and expected cost of care/treatment. I am aware that results of this care/treatment/procedure can vary from patient to patient I do understand and appreciate that particular guarante e or assurance cannot be made as to the outcome or results of the care/treatment/procedure that I may receive.

I have been explained and assured that SDHCS has instituted all necessary precautionary steps as per the guidelines to ensure that all clinical staff are symptom-free and equipped with adequate protection gears while rendering care to me or my patient.

In case of any unforeseeable events resulting in any kind of health risk or illness to me/my patient/family due to reasons which are beyond SDHCS's control, I understand and realize that SDHCS cannot be held responsible.

Release of Information

I certify that the information given by me is true to the best of my knowledge and information:

Assignment of Benefits

I Agree to pay all the charges. I am aware of my full financial obligation to SDHCS if I choose to receive them

I declare that I have received & fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my allment/care/treatment/procedure and all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion was filled in my presence at the time of my signing this form.

Patient Name..... **Patient's Signature:**.....

Thumb Impression* (Right hand for males & left hand for females)

Surrogate/: ..... **Signature:** ..... **Relationship:**.....

Guardian's Name: (only if Patient is a minor or unable to give consent)

Reason for surrogate consent: Patient is unable to give consent because-minor/Unsound mind/Unconscious

Witness or Interpreter (If applicable): .....

Signed by the above on _ _ _ _ / _ _ _ _ / _ _ _ _ _ _ at _ _ _ _ _ _ _ _ AM/PM

For Staff Use Only

I, the undersigned, have explained the details to the patient / patient representative. I am confident the he / she has understood the information fully as described in this document.

Consent obtained by:

Name:..... Designation & Dept: .....

Signature: ..... Date: .....