CENTER FOR DENTAL REHABILITATION

GENERAL AND HOSPITAL DENTISTRY

SPECIALIZING IN TREATMENT OPTIONS
FOR PATIENTS WITH SPECIAL NEEDS.
WEBSITE: WWW.DRMTOAL.COM

MAUREEN M. TOAL, DMD

LAS PALMAS MEDICAL & DENTAL PLAZA
16620 NORTH 40TH STREET, BUILDING F
PHOENIX, ARIZONA 85032
602 485-0505
FAX: 602 485-5068

CONSENT FORM

The proposed dental procedures have been explained to me and I understand the nature of my condition, the proposed treatment, and health risks which could occur if the procedures are not done.

I agree to the administration of IV sedation, general anesthesia, and/or any other therapeutic measures which may be necessary for my comfort, safety, and well being.

It has been explained to me occasionally there are complications with some dental procedures and/or medications. With any intravenous administration of medication, there is occasional inflammation, discomfort of the vein, and nausea. The more common complications to dental procedures include discomfort, swelling, bleeding, limited mouth opening, temporary tingling or numbness of the lip, tongue, cheek, or gums. There is the possibility of changes in the occlusion (bite) which could affect the temporomandibular joint and cause referred pain to the head, neck, and ear regions. In some cases, injury to adjacent teeth, delayed healing or temporary or permanent numbness to the nerves in the facial area can occur. Sinus complications may also occur from the removal of upper teeth.

Medications given during or after treatment may cause drowsiness and a lack of awareness and coordination. This could be intensified by the use of alcohol or other drugs. I have been advised not to operate any vehicle or hazardous device for at least 24 hours after surgery or while taking such medications.

I realize some of these potential complications can be avoided or reduced by carefully following Dr. Toal's instructions, which include a post-operative office visit. I have had the opportunity to ask questions about the procedures and any related issues and have had them answered to my satisfaction. This is my signed consent to allow the procedures to be performed.

I accept full responsibility for payment of treatment rendered by Dr. Maureen Toal. I understand the estimate discussed is due in full prior to the date of my appointment unless other previous arrangements have been made.

_____ _____

Signature of patient/responsible party Date

_____ _____

Witness Date

PLEASE NOTE IF FAILURE TO COMPLY WITH PRE-OP INSTRUCTIONS RESULTS IN YOUR PROCEDURE BEING CANCELLED OR ABORTED, $5,000.00 OF YOUR TREATMENT ESTIMATE WILL NOT BE REFUNDED, AND YOU WILL BE DISCHARGED FROM FURTHER SERVICE.

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PRE-OPERATIVE INSTRUCTIONS

Dr. Toal recommends that you drink plenty of fluids for at least two to three days prior to your procedure to ensure that you stay well hydrated.

Please READ and FOLLOW the instructions below. If you have any questions please contact our office at 602-485-5062.

1. Do **NOT** eat or drink anything, including water, for 8 hours prior to your procedure.

2. We realize many people take certain medications every morning. **Please discuss with your physician** whether you should continue to take these medications either the night before or the morning of your scheduled procedure.

3. Someone **MUST** drive you to the surgical facility before your procedure and home again following your procedure. This CANNOT be a TAXI, UBER or LYFT. You **will not be allowed** to leave the surgical facility alone. The person responsible for driving you should be available by phone or should remain at the surgical facility. Also, one or both parents or guardians must accompany a child (under 18 years of age) as a consent form must be signed before the procedure. If the patient does not speak English, please provide an interpreter.

4. All surgical patients are **required to be accompanied by a responsible adult for at least 24 hours following their procedure,** or plan to have an overnight stay for observation at Paradise Valley Hospital.

5. Leave all jewelry and valuables at home! Choose either casual, loose clothing, or a robe and slippers to wear. You will be given a surgical gown and cap to wear during the procedure.

6. Bathe or shower the night before or morning of your scheduled procedure. Do NOT apply any cosmetic or makeup products such as: lotion, powder, deodorant, false eyelashes, or perfume, etc.

7. Do **NOT** smoke after midnight the night before your procedure and for 24 hours after procedure.

8. Do **NOT** use alcohol and/or recreational drugs for at least 48 hours prior to your procedure and 48 hours after your procedure.

9. Contact our office if you should develop a cold, fever, or respiratory infection.

10. All patients MUST be seen by Dr. Toal following their dental procedure unless otherwise advised by Dr. Toal prior to the procedure.

Please note if failure to comply with pre-operative instructions result in your procedure being aborted, you will be charged a $5,000.00 scheduling fee before we will reschedule your next procedure.

_____ _____

Signature of patient/responsible party Date

_____ _____

Witness Date

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Consent to Discuss Treatment

I _____ hereby authorize_____

to make any decisions on my behalf and/or discuss my dental treatment with Dr. Maureen Toal and/or her staff while I am under IV Sedation/General Anesthesia.

_____ _____
Patient Signature Date

_____ _____
Witness Date

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below
Read and sign the section at the bottom of the form

☐ **1. WORK TO BE COMPLETED**
I understand that I am having the following work done: Fillings _____ Bridges_____
Crowns_____Extractions_____Surgical Extractions_____Root canal therapy_____IV Sedation_____General Anesthesia_____Other_____ (Initials _____)

☐ **2. DRUGS AND MEDICATIONS**
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction.)
(Initials _____)

☐ **3. CHANGES IN TREATMENT PLAN**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during my examination, the most common being root canal therapy following routine restorative dental procedures. I give permission to the dentist to make any/all changes and additions as necessary.
(Initials _____)

☐ **4. REMOVAL OF TEETH**
Alternative to removal have been explained to me (root canal therapy, crowns, and periodontal surgery.) and I have authorized the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spreading of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
(Initials_____)

☐ **5. CROWN, BRIDGES AND CAPS**
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.
(Initials _____)

☐ **6. DENTURES, COMPLETE OR PARTIAL**
I realize that full or partial dentures are artificial, constructed or plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the “teeth in wax” try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not including in the initial denture fee.
(Initials_____)

☐ **7. ENDODONTIC TREATMENT (ROOT CANAL)**
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy)
(Initials_____)

☐ **8. PERIODONTAL LOSS (TISSUE AND BONE)**
I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.
(Initials_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of patient _____

Date_____

Signature of Parent/Guardian if patient is a minor _____

Date _____

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Revision of Treatment Consent

I,_____, understand that I have signed and agreed to the proposed treatment plan dated,_____. I understand that there may be circumstances in which additional treatment or revisions to this treatment plan may arise during the time of procedure. I understand if any changes are to be made to this initial proposed treatment plan, that I will be advised of the changes necessary. I understand that theses changes will be identified and the need for these changes will be explained to me. I further understand that I will be required to sign a revised treatment plan within a 72 hour period and will be provided a copy.

_____ _____
Patient's Name Date

_____ _____
Patient's Signature Date

_____ _____
Legal Guardian's Signature Date

_____ _____
Witness Signature Date

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OUR FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We ask that all patients read and sign our Financial Policy as well as complete our patient information form, prior to your appointment. If you have any questions or concerns regarding our financial policy, please do not hesitate to ask.

Payment is due two weeks prior to scheduled treatment. We accept cash, checks and for your convenience, most major credit cards. We will be happy to assist you in the processing of any insurance claims for your reimbursement.

Please understand:

- Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to the contract. Our relationship is with you, not the insurance company.
- All charges are your responsibility whether your insurance company reimburses you or not. Not all services are a covered benefit. It is your responsibility to inquire about your benefits.
- If your insurance company does not reimburse you within 30 days, we suggest you contact the carrier to help speed things up.

Please note, unless a cancellation is received at least 2 weeks in advance, you will be charged for missed appointments. Please call our office if you need to reschedule an appointment.

We encourage you to communicate any financial problems or concerns, so that we can assist you in the management of your account.

We appreciate your confidence in us and look forward to serving you.

_____ _____
Signature (patient/guardian) Date

_____ _____
Witness Date

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SURGERY CANCELLATION POLICY

Due to the time and activity involved in scheduling and preparing for a surgical procedure at the Center for Dental Rehabilitation, as well as reserving the schedules of Arizona Anesthesia Consultants and Abrazo Scottsdale Campus Outpatient Facility, the Center for Dental Rehabilitation adheres to the following Cancellation Policy:

- If your surgery is canceled within 2 weeks (10 business days) of your surgery date, a $2,500.00 scheduling fee will apply.
- If your surgery is canceled within 1 week (5 business days) of your surgery, a $4,000.00 cancellation fee will apply.
- If general anesthesia was recommended by Dr. Toal and patient wants IV sedation and sedation by IV is not achieved, the case will be aborted, then the patient will be responsible for the cost of General Anesthesia as well as facility fees.

Cancellation notifications will *not* be accepted on messages left with the answering machine or the after hours emergency phone.

Our business hours are as follows:
Monday - Thursday 7:00 a.m. – 4:00 p.m.
Friday 8:30 a.m. – 1:00 p.m.

We realize that extenuating circumstances may exist that may prevent you from fulfilling your obligation. If it is necessary to postpone your surgery due to an emergency or health issue, please advise our office as soon as possible. We will retain your surgery funds until you are able to proceed with surgery.

I have read the above and will be bound by the terms thereof.

_____ _____
Signature of patient or responsible party Date

_____ _____
Witness signature Date

D E C I S I O N S

►►►►►►►►►►►►About Your Healthcare

How you can plan for the future with living wills and other healthcare directives?

You are getting this information about your rights to make or control your own healthcare decisions. We hope this information will help you. A description of this healthcare organization's policies about your right to make healthcare decisions must be given to you along with this information. You are also encouraged to talk with your family, doctor, and anyone else who could help you in these matters.

◄◄◄◄◄◄◄◄◄◄◄◄◄◄

Q **Who makes your healthcare decisions?**

A You do—if you can make and communicate them. Your doctors should tell you about the treatment they recommend, other reasonable alternatives, and important medical risks and benefits of that treatment and the alternatives. You have the right to decide what healthcare, if any, you will accept.

Q **What happens if you become unable to make and/or communicate decisions about your healthcare?**

A If you have planned ahead, you can still have some control over your healthcare decisions. One way to plan ahead is by making a healthcare directive which names someone to make these decisions for you, or controls these decisions. If you have not named someone in a healthcare directive, your doctor must seek a person authorized by law to make these decisions. A person who makes healthcare decisions for you is called a surrogate.

Q **What is a healthcare directive?**

A It is a written statement about how you want your healthcare decisions made. Under Arizona law, there are four types of healthcare directives. **They are:**

A healthcare power of attorney, in which you name an adult to make healthcare decisions for you. That person will make healthcare decisions for you only when you cannot make or communicate such decisions.

A mental healthcare power of attorney, in which you name an adult to make mental healthcare decisions for you. That person will make mental healthcare decisions for you **only** when you cannot make or communicate such decisions.

A living will, in which you tell others about the healthcare you do or do not want if you are ever unable to make your own healthcare decisions. For example, a living will can say whether you would want to be fed through a tube if you were unconscious and unlikely to recover.

A prehospital medical care directive, in which you refuse cardiopulmonary resuscitation (CPR), a type of lifesaving emergency care, if you have a heart attack or can't breathe on your own. To make one, you must complete a special form.

These directives, used separately or together can help you accept treatment you want and refuse treatment you do not want.

Q **Must your healthcare directives be followed?**

A Yes. Both healthcare providers and surrogates must follow valid healthcare directives.

Q **Can you be required to make a healthcare directive?**

A No. Whether you make a healthcare directive is entirely up to you. A healthcare provider cannot refuse care based on whether or not you have a healthcare directive.

Q **Can you change or revoke healthcare directives?**

A Yes. If you change or revoke a healthcare directive, you should notify everyone who has a copy.

Q **Who can legally make healthcare decisions for you if you are unable to make your own decisions and if you have not made a healthcare power of attorney?**

A A court may appoint a guardian to make healthcare decisions for you. Otherwise, your healthcare provider must go down the following list in order of priority to find a surrogate to make healthcare decisions for you:

1. **Your spouse** (unless you are legally separated).
2. **Your adult child** (if you have more than one adult child, a majority of those who are available).
3. **Your parent**
4. **Your domestic partner** (unless someone else has financial responsibility for you).
5. **Your sibling**
6. **A close friend of** yours (someone who shows special concern for you and is familiar with your healthcare views).

If your healthcare provider cannot find an available and willing surrogate to make healthcare decisions for you, then your doctor can decide with the advice of an ethics committee,

or if this is not possible, with the approval of another doctor.

You can stop anyone from becoming your surrogate by saying, preferably in writing, that you do not want that person to make healthcare decisions for you.

A surrogate will **not** have the right to have tubes withdrawn from you that are used to give you food or fluids unless:

- You have appointed that surrogate to make healthcare decisions for you in a healthcare power of attorney; or,
- A court has appointed that surrogate as your guardian to make healthcare decisions for you; or,
- You have stated in a healthcare directive that you do not want this specific treatment.

Additional information for anyone who already has or wants to make a healthcare directive…

Q What if you already have a living will or other healthcare directive?

A A healthcare directive which was valid when made anywhere in the U.S. is valid under Arizona law. However, Arizona law changed on September 30, 1992, making new choices available to you. You should review your healthcare directives periodically and update them as needed.

Q Do you need a lawyer to make a healthcare directive?

A No. Just be sure that your directive is valid under Arizona law.

Q What does the law require for a healthcare directive after September 30, 1992?

A A healthcare power of attorney or mental healthcare power of attorney must:

- Name a person to make healthcare decisions for you if you become unable to make your own decisions. You may also name an additional person or persons to make decisions for you if your first choice cannot serve. The person or persons must be at least 18 years old.
- Be signed or marked by you and dated. If you are unable to sign, the witness and notary, at your direction, can state in writing that the power of attorney states your wishes and that you want to do the power of attorney.
- Be signed by a notary or by an adult witness or witnesses, who saw you sign or make the document and who say that you appear to be of sound mind and free from duress. A notary or witness cannot be the person you name to make your decisions and cannot be providing healthcare to you. If you have only one witness, that witness cannot be related to you or someone who will get any of your property from your estate if you die.

A living will must:

- State how you want your healthcare decisions to be made in the future.
- Be signed or marked by you and dated.
- Be notarized or witnessed in the same way as described above for a healthcare power of attorney.

Q Who should have copies of your health care directives?

A It is very important that you give copies to your doctors at once and to any healthcare facility upon admission. You should give copies to anyone you have named to make healthcare decisions for you in a healthcare power of attorney. You may also want to give copies to close family members. Be sure to keep extra copies for yourself.

Sources of Information and Forms

The following organizations provide healthcare directive forms and information:

Aging & Adult Administration
State of Arizona
1789 W. Jefferson
Site code 950A
Phoenix, AZ 85007
602-542-4446

Dorothy Garske Center
4250 East Camelback Road
Suite 185K
Phoenix, AZ 85018
602-952-1464
www.dgcenter.org

Area Agency on Aging--Region One
1366 E. Thomas Road
Phoenix, AZ 85014
602-264-2255

The following national organization also provides healthcare directive forms and information:

Partnership for Caring
1620 Eye Street, NW, Suite 202
Washington, D.C. 20006
1-800-989-9455
www.partnershipforcaring.org

Toal Surgical Center
Maureen M. Toal, D.M.D.

POLICY ON ADVANCE DIRECTIVES FOR HEALTHCARE DECISIONS

The Toal Surgical Center requires all staff members to recognize the statutory right of a patient who is a competent adult to decide whether to receive or refuse medical treatment. This decision may be in the form of Advance Directives for Healthcare Decisions ("Advance Directive").

If an adult patient is unable to make or communicate healthcare treatment decisions, Toal Surgical Center shall make a reasonable effort to locate and shall follow a healthcare directive. The Toal Surgical Center shall also make a reasonable effort to consult with a surrogate.

The Toal Surgical Center will not discriminate against a patient based on the existence or non-existence of an Advance Directive.

Any staff member of the Toal Surgical Center who is unable or unwilling to comply with this policy shall not impede or prevent any other staff member from complying with this policy.

An attending physician who is unwilling or unable to follow the Advance Directive of a patient shall, without delay, transfer the patient, or not hinder the transfer of the patient to another physician who will follow the Advance Directive.

At the time of pre-op for or at the time of outpatient surgery, each adult patient shall be provided with written information titled "Decisions -- About Your Healthcare" and a written summary of the Toal Surgical Center Policy on Advance Directives. Each adult patient shall also sign the Advance Directive Acknowledgement.

Advance Directives provided to the Toal Surgical Center by the patient shall be placed in the patient's medical record.

Any attempt by the patient to revoke an Advance Directive shall be honored.

Toal Surgical Center
Maureen M. Toal, D.M.D.

ADVANCE DIRECTIVE FOR HEALTHCARE DECISIONS ACKNOWLEDGEMENT

We are required by Federal Law to make you aware of your right to be involved in decisions regarding your healthcare. Specifically, you have the right to execute an Advance Directive for Healthcare Decisions ("Advance Directive") in the form of a Healthcare Power of Attorney, a Mental Healthcare Power of Attorney, a Living Will, or A Pre-Hospital Medical Care Directive.

To help you better understand your rights, both an information sheet titled "Decisions -- About Your Healthcare" and a summary of the Toal Surgical Center's policy of Advance Directives are being furnished to you.

I have received the following information:

- Decisions – About Your Healthcare ○ YES ○ NO
- Summary of the Toal Surgical Center Policy on Advance Directive ○ YES ○ NO

I have executed a current Advance Directive of the following type:

☐ A Healthcare Power of Attorney ☐ A Mental Healthcare Power of Attorney
☐ A Living Will ☐ A Pre-Hospital Medical Care Directive

Copy location: Name: _____
Address: _____
_____
Phone: _____

_____ _____
Patient Signature **Date/Time**

If patient is a minor or unable to sign, please complete the following:

☐ Patient is a minor _____
Parent's Signature

☐ Legal Guardian _____
Signature

☐ Power of Attorney _____
Signature

_____ _____
Witness Signature **Date/Time**

Toal Surgical Center
Maureen M. Toal, D.M.D.

PATIENT RIGHTS

1. The patient has the right to be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and care for personal needs.

2. The patient has the right to be free from medical, psychological, physical and chemical abuse or neglect.

3. The patient has the right to be free from physical restraints, with the exception of an emergency situation where a restraint is necessary to protect the patient from injury to self or others, and is authorized by the attending physician.

4. The patient has the right to refuse any treatment, withdraw consent for treatment, or to give conditional consent for treatment.

5. The patient has the right to have medical and financial records kept in confidence and the release of such records shall be by written consent of the patient or the patient's representative except as otherwise required or permitted by law.

6. The patient has the right to access to the patient's medical record.

7. The patient has the right to be informed of rates and charges for services offered or prior to change in rates, charges, or services and advised of possible third party coverage.

8. The patient has the right to be advised on the facility's policy regarding Advance Directives.

9. The patient has the right to be included in decisions regarding care and treatment.

10. The patient has the right to associate and communicate privately with persons of the patient's choice.

11. The patient has the right to have access to a public telephone.

12. The patient has the right to submit grievances without retaliation.

13. The patient has the right to exercise other civil rights and religious beliefs.

Patient Signature **Date/Time**

Witness Signature **Date/Time**

Submit