8. **Risks of treatment:** The faculty at UTHSCSA-DS is available to answer any questions concerning the risks involved with specific procedures. All dental procedures have certain risks; including possible side effects from some medicines used in dentistry. These risks include, but are not limited to:
   a) allergic reactions    b) cuts/abrasions    c) tenderness/bruising from    d) sensitive teeth injections

9. **Follow-up appointments:** I understand that by accepting treatment at UTHSCSA-DS I also consent to future follow-up appointments for the purpose of assessing the outcome of the dental treatment provided to the patient.

10. **Consent to photograph:** I understand that photographs, videotapes, digital, and other images may be recorded to document and assist with my care. These images may be used to assist in the education of students and residents within the institution. I understand that UTHSCSA will own these images, but that I will be allowed access to view them or to obtain copies of them at a reasonable cost. Other than for treatment and education purposes, images that identify me will be released and/or used outside the organization only upon written authorization from me or the patient representative.

11. **Notice of Privacy Practices:** UTHSCSA may release information to other entities or health care providers, for treatment, payment of services, and for health care operations as described in the "Notice of Privacy Practices". UTHSCSA has prepared this detailed document to help you better understand our policies in regard to the use and disclosure of your personal health information.

I have been given the opportunity to review and receive a copy of the Notice of Privacy Practices.  

*Please initial:* ______

12. **Research Study:** If my oral health problems or treatment needs could possibly qualify me for a clinical research study, I give permission for my information to be forwarded to the principle investigators.  

*Please initial:* ______

13. **Consent to treatment:** By signing below, I am indicating that I have read and I understand the terms of the Consent and Agreement for Treatment. I am either the patient or have the authority to give consent for the patient. I give consent to the UTHSCSA-DS to perform necessary or appropriate tasks for proper dental and physical examination, diagnosis, and treatment, including local anesthesia.  

*My questions regarding this consent and agreement have been answered.*

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**Patient or Patient Representative Signature**

**Date**

**If Patient Representative, Relationship to Patient**

**Witness**

**07-01-06**

**Consent and Agreement for Treatment**