Consent for Anesthesia

I hereby agree to give my unqualified consent for the administration of any anesthetic agent deemed necessary by the anesthesiologist, Daniel Kohanchi, DDS. I also understand that the anesthesiologist will have full charge of the administration and maintenance of the anesthesia, and that **this is an <u>independent</u> function from other procedures being performed.**

I have been informed and understand that occasionally there are complications associated with drug administration, including but not limited to: venous inflammation (phlebitis), breathing (respiratory) difficulties, heart (cardiovascular) difficulties, death, stroke, seizure, nerve damage, awareness, allergic reactions, and other adverse drug reactions. If a complication should arise, I expect that only the anesthesiologist will proceed to the best of his abilities. I certify to the best of my knowledge that all medical information provided to Dr. Kohanchi and/or his staff is true and complete.

I have been made aware that risks associated with local anesthesia, sedation, and general anesthesia may vary. Although local anesthesia usually presents the least risk, I also realize that this type of pain control may not be appropriate for every patient or procedure.

It is also understood that the effects of the anesthetic agents may be harmful to a developing fetus, and may even cause spontaneous abortion, or miscarriage, therefore, I accept full responsibility for informing Dr. Kohanchi of a suspected or confirmed pregnancy with the understanding that this may necessitate the postponement of the anesthetic. I understand that I must inform Dr. Kohanchi if I am a nursing mother as well.

I understand that the anesthetic agents used will cause drowsiness, lack of awareness and coordination, and that these side effects could be increased by the use of alcohol or other drugs/medications. Therefore, I have been advised and agree to avoid operating any vehicle or hazardous devices for at least twenty-four (24) hours or longer until fully recovered from the effects of the anesthetic. I have also been advised to not make any major decisions during this recovery period. All of my questions have been asked and answered and the risks and benefits deemed appropriate that I agree to proceed with anesthesia willingly.

Patient Name (print): ______________________________

Signed: __________________________________ Date: ____________________

Relationship to patient (if not patient): ________ Date: ____________________

Consent obtained personally by the anesthesiologist: : _________________________

Financial Responsibility

I am aware that fees for the delivered anesthetic services are determined by the time, surgical complexity, medical condition, and course of recovery of the patient. I was informed that the anesthetic charges for my scheduled procedure are based on SoCal Sleep Dentistry's fee schedule. I am aware that I am responsible for the entire fee for the anesthesia services provided by the anesthesiologist. I authorize that any payments of benefits for anesthesia services rendered be made directly to SoCal Sleep Dentistry, my signature below authorizes charges to my credit card for anesthesia services rendered if I choose this as a means of reimbursement to SoCal Sleep Dentistry. Balances over thirty (30) days are subject to a 2% monthly (24% annual) service charge. I have also been informed that I am responsible for any charges rendered by a collections company should my account be turned over for collections, or any legal fees should legal action become necessary for fee collection.

Financial Responsible Party

Signed: __________________________________ Date: ______________

SoCal Sleep Dentistry

(818) 351-9737

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices in this Notice while they are in effect. If you have questions about this Notice, please contact the Privacy Officer at this practice.

How we may use and disclose health information about you

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Not every possible use or disclosure in a category is listed.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the services that you receive from us. Payment activities include billing, collections, claim management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or a third party. For example, we may send claims to your insurance company containing certain health information.

Healthcare Operations. We may use and disclose your health information to assure that you receive the highest possible care. For example, we may use your health information to review our treatment and services and to evaluate the performance of our staff.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family, friends, or any other individual identified by you when they are involved in your care or in the payment for your care.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization:

*To assist in disaster relief efforts
*When required by law
*To avoid a serious threat to public safety
*When authorized for national security
*When requested by the U.S. Dept. of Health and Human Services
*To workers' compensation or similar programs for claims processing
*As required by law enforcement to assist in an investigation
*Health oversight activities
*In response to a legal proceeding
*For research that has been approved by an IRB or privacy board
*To coroners, medical examiners, or funeral directors

We may contact you to provide you with appointment reminders or information about treatment activities or other health-related benefits and services that may be of interest to you.

Other Uses or Disclosures of Protected Health Information Requiring Your Written Authorization

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use of Protected Health Information for marketing, and for the sale of Protected Health Information. You may revoke an authorization in writing at any time. If you revoke authorization, we will no longer use or disclose your health information for the reasons covered in the written authorization.

Your Health Information Rights

Access. You have the right to look at or request copies of your health information, with limited exceptions. You must make the request in writing to the Privacy Officer of this Practice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information. You must make the request in writing to the Privacy Officer of this Practice.

Right To Request a Restriction. You have the right to request additional restrictions on the use and disclosure of your health information. You must make the request in writing to the Privacy Official of this Practice. The written request must include (1) what information you want limited, (2) whether you want to limit the use, disclosure, or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to an insurance plan for the purpose of carrying out payment and the information pertains solely to a health care service for which you have paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make the request in writing to the Privacy Officer of this Practice. Your request must include the alternative means or location and provide satisfactory information as to how payments will be handled under the alternative means or location you request. If we are unable to contact you using the alternative means or locations that you have requested, we may contact you using the information that we have.

Amendment. You have the right to request that we amend your health information. You must make the request to the Privacy Officer of this Practice. Your request must include the health information that you would like to have amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your records and notify you of such. If we deny your request, we will provide you with a written explanation of why we denied it.

Right To Notification of a Breach. You will receive notifications of breaches of your unsecured health information as required by law.

Changes To This Notice. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information that we already have about you as well as any health information that we receive from you in the future.

Our Privacy Official: Daniel Kohanchi, DDS
Telephone: 818-351-9737

Acknowledgement of Receipt of Notice of Privacy Practices

PRINT PATIENT'S NAME: ______________________________

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: ______________________________

DATE: ____________________