Dr. A.M. Kahane, Inc

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CONSENT TO TREATMENT FOR INTERNATIONAL PATIENTS

Patient: ________________________ Date: _________ Expected Treatment Duration: ___________

1. I authorize Dr. Amos and/or Dr. Marcela Kahane, or whomever they may designate, to perform the following procedure(s) and treatment on _____________________________(name of patient)

____
Nature of procedure(s), treatment, and anesthetic (list type of anesthetic to be used)

If during the course of such treatment in their opinion and judgment any treatment or procedure different from that now contemplated should be indicated in respect of which there is no reasonable opportunity for additional explanation and authorization, I further request and authorize them to do whatever they consider advisable.

2. The nature and purpose of the treatment, possible alternative methods of treatment, the risks involved and the possible complications have been fully explained to me by Dr. Amos and/or Marcela Kahane.

3. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.

4. I consent to the administration of the anaesthetics names above (if any) or any such other anaesthetics as may be considered necessary or advisable by the dentist referred to herein or any treating dentist.

5. I confirm that I have discussed the method and terms of payment for the treatment described in paragraph (1) with Dr. Amos Kahane and/or Dr. Marcela Kahane and that I have agreed to make such payment on the terms we discussed.

I AGREE I SHALL BE GOVERNED IN ACCORDANCE WITH THE LAWS OF THE PROVINCE OF BRITISH COLUMBIA, CANADA. I ALSO ACKNOWLEDGE AND AGREE THAT THE COURTS OF THE PROVINCE OF BRITISH COLUMBIA, CANADA, SHALL HAVE THE EXCLUSIVE JURISDICTION TO DEAL WITH ANY COMPLAINTS, DEMANDS, CLAIMS, DISPUTES, CAUSES OF ACTIONS OR PROCEEDINGS, INCLUDING WHETHER THEY ARE BASED ON ALLEGED BREACH OF CONTRACT OR ALLEGED NEGLIGENCE ARISING OUT THE TREATMENT OR SERVICE PROVIDED TO ME BY THE DENTISTS; THEIR EMPLOYEES, ASSOCIATES, STAFF, OR ANYONE ACTING UNDER OR WITH THEM.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT AND THAT THE EXPLANATIONS REFERRED TO WERE IN FACT MADE TO ME AND THAT THE FORM WAS FILLED IN PRIOR TO TREATMENT

______________________________ Signature of Patient

______________________________ Signature of Parent / Guardian

______________________________ Relationship to Patient

Note: When a patient is a minor or is otherwise incompetent to give consent, the consent of a parent, guardian or substitute decision-maker must be obtained.

Witness: In my opinion, the patient/parent/guardian appears to understand the treatment proposed and the information provided concerning the treatment.

______________________________ Witness

______________________________ Signature of Witness