COVID-19 Dental Treatment Consent & Waiver

As you are all aware, the world is dealing with a global pandemic. Coronavirus, or COVID-19, has disrupted all of our lives. We believe in keeping all of our employees and patients safe and protected. We have been following the recent COVID-19 outbreak, and we believe strongly in following all recommendations issued by local, state, and federal authorities to keep our workforce and patients safe and healthy and prevent the further proliferation and transmission of the COVID-19 pandemic.

If you are sick, the CDC advises that you wear a facemask, and call any medical provider you plan to visit before your arrival, so that the physicians, staff, and other patients can remain protected. Please continue to wash your hands, disinfect high-touch surfaces, and avoid sharing personal items. More information can be found on the CDC's website at CDC.gov.

Our dental office is always taking preventative measures in our physical space to prevent the further proliferation and transmission of the COVID-19 pandemic, but unfortunately, this is an invisible enemy. Therefore, to ensure elective or emergency treatment during this pandemic, we must insist on you reviewing and signing the following consent and waiver.

Please Review & Complete

By signing this document I, _____ (parent/guardian's name), now agree that I consent to waive certain legal rights, including the right to sue _____ (dentist name), and, if applicable, its owners, dentists, hygienists, representatives, and facilities from any physical, material, tangible or intangible loss or damage that may happen to me during my participation in any elective or emergency dental treatment (from now on, "Dental Treatment").

Name of Dental Treatment Provider: Hubert J. Park, DMD, MPH

Address: 77 Broad Street, Lynn, MA 01902

Phone Number: (781)599-2900

Email: info@broadsmilespdo.com

I am voluntarily receiving Dental Treatment from the Dental Treatment Provider listed above. Dental Treatment will include the following:

The following is the identifying and contact information for me, the patient ("Patient"):

Parent/Guardian Legal Name:

Address:

Phone Number:

Patient's Legal Name:

Date of Birth:

The contact information of my emergency contact is as follows:

Emergency Contact Name:

Emergency Contact Phone Number:

Emergency Contact Relationship:

My initials below indicate that I agree with and understand the following:

_____It is my responsibility to consult a physician before participating in any dental treatment, and I affirm that I have no medical conditions that would restrict me from participating in dental treatment.

_____I agree to hold the Dental Treatment Provider, its owners, dentists, hygienists, representatives, and facilities harmless from any damage, whether tangible or intangible that may happen to me while participating in the Dental Treatment.

_____I agree that the Dental Treatment Provider offers the Dental Treatment with no guarantee of not contracting COVID-19. I agree that any consequences that occur, whether positive or negative, are the effects of my own choices.

_____ I acknowledge that participation in the Dental Treatment is not a replacement for actual medical care for symptoms of COVID-19 and that if I do experience medical issues or symptoms, I will contact my doctor immediately.

_____I understand and agree that it is my responsibility to let the Dental Treatment Provider know in advance if I find myself experiencing symptoms of Coronavirus/COVID-19.

(Symptoms can mimic those of the flu and may present differently in different individuals. Some common symptoms are:

- Fever

- Cough

- Shortness of breath

Symptoms can appear anywhere between 2 and 14 days after exposure, according to the information we currently have).

_____I agree and verify that all of the information that I have given the Dental Treatment Provider and its representatives is accurate, up-to-date, and without the omission of any known medical issues.

_____I agree and verify that if I have omitted any necessary personal information, whether knowingly or unknowingly, I will hold the Dental Treatment Provider harmless against all liability for any damages that may occur to myself or others because of my actions or inactions.

_____I agree to keep the Dental Treatment Provider apprised of any changes or upcoming changes concerning my physical health and personal information.

_____If I do require medical treatment or attention while or after participating in the Dental Treatment, I agree that the medical costs are mine and mine alone. I will hold the Dental Treatment Provider blameless from any charges, fees, or expenses that my conditions may incur.

This Dental Treatment Consent & Waiver will bind and be enforceable against me and all of my representatives. I agree that this Dental Treatment Consent & Waiver should be binding to the fullest extent of the law. If any portion is held invalid, the remainder should continue in full legal force and effect.

I expressly acknowledge and agree that this document is not intended to be a general release, which would be limited under some state and local laws.

This Dental Treatment Consent & Waiver shall be construed and interpreted as broadly as possible in the applicable jurisdiction.

ASSUMPTION OF RISK: I understand and am aware that my participation in the Dental Treatment involves risks. These risks may lead to tangible or intangible harm, and I agree that they may result not only from my actions but also from the actions of others. With the knowledge and understanding of these risks, I choose, of my own will and volition, to continue participating in this elective or emergency Dental Treatment.

I am also aware that there are risks that I may not have considered, yet I waive my right to any claims that may occur from these unconsidered risks, and I choose, of my own will and volition, to participate in the Dental Treatment.

COVENANT NOT TO SUE: I will not start any lawsuit or other court action against the Dental Treatment Provider or facility. I will not join any such proceeding, including any claim for money damages. I acknowledge that I am entering a covenant not to sue the Dental Treatment Provider in any capacity, including to hold the Dental Treatment Provider liable for any injury, loss, or damage sustained by me or my property, even if it is due to the Dental Treatment Provider's negligence or omission. I also waive the right of any of my insurers' to make any such claim.

INDEMNIFICATION: I agree to defend and indemnify this Dental Treatment Provider and any of its affiliates (if applicable). I agree to hold them harmless against all legal claims and demands, including reasonable attorney's fees, which may arise from or relate to my use or misuse of the Dental Treatment or my conduct or actions. I agree that the Dental Treatment Provider shall be able to select its legal counsel and may participate in its defense if desired.

REPRESENTATION: I am over 18 (eighteen) years of age and am medically and physically able to participate in the Dental Treatment.

GOVERNING LAW: This Dental Treatment Consent & Waiver shall be governed by and construed under the internal laws of Massachuetts without giving effect to any choice or conflict of law provision or rule. Each party irrevocably submits to the exclusive jurisdiction and venue of the federal and state courts located in the county of Essex in any legal suit, action, or proceeding arising out of or based upon this Dental Treatment Consent & Waiver.

I have read the above Dental Treatment Consent & Waiver fully, and I understand and agree to its contents. By signing this Dental Treatment Consent & Waiver I understand that I forfeit any right, claim, or ability to hold the Dental Treatment Provider responsible for any tangible or intangible damages, loss of property, or loss of life that may occur during or after my use of the facilities and participation in the Dental Treatment.

_____

Patient's Name

_____

Parent/Guardian's Name

_____

Parent/Guardian's Signature

_____

Date