## LIABILITY DISCLAIMER FOR TREATING PATIENTS FROM OUTSIDE OF CANADA

# CONSENT TO TREATMENT

**Name of Patient**_____

**Date**_____ **Expected Duration of Treatment**_____

**1.** I authorize Dr._____, or whomever he/she may designate to perform the following procedure(s) and treatment on _____
*(Name of patient – or myself)*

_____
*(State nature of procedure(s) and treatment and, if anaesthetic is to be administered, the type of anaesthetic to be used)*

and if during the course of such treatment in his/her opinion and judgement 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 him/her to do whatever he/she considers advisable.

**2.** The nature and purposes of the treatment, possible alternative methods of treatment, the risks involved and the possible complications have been fully explained to me by

_____
*(Name of dentist(s) explaining)*

**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 named above (if any) or any such other anaesthetics as may be considered necessary or advisable by those dentists referred to in this consent.

**5.** I understand that this Consent to Treatment form and the treatment provided as described in paragraph 1 above will be governed by the laws of the Province of _____
*(insert province where treatment rendered)*

and I consent to the courts of the Province of _____
*(insert province where treatment rendered)*
having exclusive jurisdiction to entertain any action, suit or proceeding in respect of, or in any way relating to, such treatment.

**6.** I confirm that I have discussed the method and terms of payment for the treatment described in paragraph 1 with Dr. _____and that I have agreed to make such payment on the terms we discussed.

**GOVERNING LAW**

The Patient agrees that the relationship between himself/herself and the dentist shall be governed and construed in accordance with the law of the Province of British Columbia, Canada.

**JURISDICTION**

The Patient acknowledges that the treatment or service, or both, is to be performed in the Province of British Columbia, Canada. The Patient acknowledges and agrees that the Court of the Province of British Columbia shall have exclusive jurisdiction with respect to any legal actions or proceedings among the parties including any actions or proceedings with respect to any breach of contract or negligence arising out of the treatment or service, or both, provided to the patient by the dentist or his or her employees, staff, or associates.

The Patient agrees that he or she will commence such legal actions or proceedings only in the Province of British Columbia hereby submits to the exclusive jurisdiction of this Province.

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 _____

Or

Signature of Parent or Guardian _____

*(or other person authorized to consent for patient)*

Relationship of Person Signing, 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 able to understand the treatment proposed and the information provided concerning the treatment.

Signature of Witness _____