YOON H. CHANG • DDS MS

3D Cone Beam CT Imaging
Consent/Acknowledgment/Release and Waiver of Scope of Services

Date:

I,______________________________, hereby consent to Dr. Yoon Chang at E Line Orthodontics to take a 3D cone beam imaging on (patient name)_________________________ to provide tentative orthodontic treatment options.

I was explained that the ICAT 3D Cone Beam Imaging quick scan will produce a radiation dosage equivalent to 6-7 days of ordinary background average radiation. I further understand that the purpose of taking 3D imaging is to ONLY provide orthodontic treatment option and NOT a professional interpretation or diagnosis of any cranio-facial structures, surrounding soft tissue or associated pathologies.

In consideration of the waiver of all costs and services through Dr. Yoon Chang at E Line orthodontics, I do hereby, or on behalf of (patient name)___________________________, now and forever release and discharge Dr. Change, his agents, employees, professional corporation, insurers and assigns from any loss, costs, damages or expenses arising out of taking 3D Cone Beam CT Imaging, advice, diagnoses, and treatment by said Doctor, his/her agents or employees to Patient.

I further understand that by executing this form, and accepting the specific consideration as recited above, the patient and anyone claiming through or on behalf of patient will be forever foreclosed from any claim for damages arising out of the orthodontic services, advice, diagnosis, and treatment by said Doctor, his/her agents or employees.

The terms of this form are to be kept confidential by me, and will not be disclosed to anyone without the written authorization of said Doctor or an order from a court of competent jurisdiction.

This form and the consideration recited herein is not and shall not be constructed to be an admission of liability on the part of anyone, including, but not limited to, said Doctor, his/her agents or employees.

There will be $250 fee for duplication of imaging and release. (will be reimbursed after insurance payment only if applicable)

Patient Name:_______________________________________

Responsible Party Signature:______________________________

Relationship to Patient:________________________________

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