

Widner Oral & Maxillofacial Surgery
1500 West 38th St., Suite 51
Austin, Texas 78731

**RELEASE AND CONSENT FOR PERFORMANCE OF DIAGNOSTIC
CONE BEAM 3-D IMAGING**

You have the right to be informed about your condition and the recommended treatment plan so that you may make an informed decision after knowing the risks. This disclosure is meant to properly inform you so that you may give or withhold your consent. The i-CAT™ cone beam CT provides imaging of the maxillofacial area producing the most complete anatomical information on a patient's mouth, face, jaw, and soft tissue. The purpose of your scan is for oral and maxillofacial diagnostic purposes only.

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK BEFORE INITIALING.

____ **PROCEDURE** – I hereby freely and willingly consent to Dr. Steve Widner and his assistants to perform the Cone 3-D Imaging Tomography.

____ **RISKS** – I understand that there are certain inherent and potential risks in the use of radiation, that in this specific instance such risks have been minimized by the use of a highly collimated X-ray beam.

____ **PREGNANT WOMEN** – If you are a woman, you will be questioned regarding pregnancy. If you are pregnant, or you are unsure if you are pregnant, you be given the option not to to have the scan taken due to the unknown risk of the embryo or fetus from the scan.

____ **RELEASE** - I authorize Dr. Steve Widner and his employess to release any information and records concerning my treatment as may be necessary to process insurance claims or payment for the care and treatment provided or to other healthcare professionals for assessment.

____ **REFUSAL OF PROCEDURE** – Your decision to undergo this scan is voluntary. You may refuse to participate or discontinue participation at any time. However, you should be aware that this procedure has been recommended to provide information that is not clinically available. Refusal of the procedure will result in lack of information, which could result in a less than optimum treatment for your condition.

____ **INTERPRETATION** – Your scan will be read and interpreted by Dr. Widner. However, you may request that your scan be reviewed and interpreted by a radiologist. You will be responsible for any separate fees charged by the radiologist.

_____ Please initial here if you would like to have a radiologist read your scan.

You will be given a copy of this form to keep.

Patient's (or legal guardian's signature)

Date

Doctor's Signature

Date

Witness' signature

Date