Todd Morgan
DENTAL CORPORATION

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INFORMED CONSENT FOR THE TREATMENT OF SLEEP DISORDERED BREATHING WITH ORAL APPLIANCE THERAPY (OAT)

Snoring and obstructive sleep apnea (OSA) are both breathing disorders that occur during sleep due to a narrowing or total closure of the airway. Snoring is a noise created by partial closure of the airway and may be no more problematic than the noise itself. However, consistent, loud, heavy snoring has been linked to medical disorders such as obstructive sleep apnea. Obstructive sleep apnea is a serious medical condition in which the airway totally closes many times during the night and can significantly reduce oxygen levels in the body and disrupt sleep. In varying degrees, this can result in excessive daytime sleepiness, irregular heartbeat, high blood pressure, reflux, depression, heart attack and stroke.

Any sleep disordered breathing may represent a health risk. All individuals will be tested by an overnight home sleep study or by a polysomnogram in a sleep laboratory.

Oral appliances may be helpful in the treatment of snoring, upper airway resistance syndrome (UARS), and obstructive sleep apnea. Oral appliances are designed to assist breathing by advancing the jaw and tongue slightly forward, thereby opening the airway passage. While documented evidence exists that oral appliances have substantially reduced snoring and sleep apnea for many people, there are no guarantees that this therapy will be successful for every individual. Several factors contribute to the snoring/apnea condition including nasal obstruction, narrow airway space in the throat and excess weight. Each person is different and presents a unique circumstance, therefore oral appliances will not reduce snoring and/or apnea for everyone. A sleep study or other objective tests following treatment will be necessary to assure effectiveness.

POSSIBLE COMPLICATIONS: Some people may not be able to tolerate the appliance in their mouth and will develop temporary adverse side effects such as excessive salivation, sore jaw joints, sore teeth and a change in their bite. However, these usually diminish within an hour after the appliance removal. On occasion, a permanent bite change may occur due to jaw joint changes and/or tooth movement. Generally this can be minimized with the exercise leaf gauge or other techniques you will be shown. These complications may or may not be reversible once the appliance therapy is discontinued. If not, restorative, orthodontic and/or surgical treatment may be required, which you are responsible for. Oral appliances can wear and break. There is a possibility that broken parts may be swallowed and aspiration exists. For patients with sleep apnea, the device must be worn nightly. Long-term discontinuation of use is a hazard to your health and can lead to a heart attack, stroke or even death. See your prescriber before discontinuing use and for recommendations of alternative therapy such as CPAP and/or surgery.

LENGTH OF TREATMENT: The oral appliance is strictly a mechanical device to maintain an open airway during sleep. It does not cure snoring or sleep apnea. The device must be worn nightly for a lifetime to be effective. Simple snoring may develop into sleep apnea and may become worse. Therefore, the appliance may not maintain its' effectiveness. The oral appliance needs to be checked at least twice a year to ensure proper fit, and the mouth will be examined at that time to assure a healthy evaluation. If any unusual symptoms occur, you are advised to schedule an office visit to evaluate the situation. Individuals who have been diagnosed with sleep apnea may notice that after sleeping with the oral appliance they feel more refreshed and alert during the day. This is only

subjective evidence of improvement and may be misleading. The only way to accurately measure whether the appliance is keeping the oxygen level sufficiently high to prevent abnormal heart rhythms and other problems is to be retested with an overnight sleep study.

ALTERNATIVE TREATMENTS: Other accepted treatments for sleep-disordered breathing include behavior modification, weight loss, CPAP and surgery. These alternative treatment modalities have been explained and you have chosen oral appliance therapy to treat your particular problem, and are aware that it may not be completely effective for you.

UNUSUAL OCCURRENCES: As with any form of medical or dental treatment, unusual occurrences can and do happen. Broken or loosened teeth, dislodged dental restorations, mouth sores, muscle spasms and ear problems are all possible occurrences. Most of these complications and unusual occurrences are infrequent. Additional medical and dental risks that have not been mentioned may occur. Good communication is essential for the best treatment results. Please call or come in if you have any questions or concerns regarding treatment.

DOCTOR'S OFFICE PHONE:
San Diego (619) 299 - 6299
Encinitas (800) 619 - 4672
Escondido (800) 619 - 4672

I understand my responsibilities to be:

1.) To contact Dr. Morgan immediately if I notice any change (beyond common, transient changes described to me) in my bite, mouth musculature or any other tissue/structure possibly associated with the use of the device.

2.) To have dental examinations no less in frequency than every 6 months.

3.) To be compliant with the daily exercises prescribed to me, intended to avoid bite changes over time.

4.) At some point, after you have received your device, Dr. Morgan will want a progress sleep performed with the oral appliance to ensure efficacy.

I certify that I have read or had read to me, the contents of this form. I realize and accept any risks and limitations involved, and do consent to treatment. I give consent for Dr. Morgan to consult with my physicians regarding this disorder to exchange my medical records to assist him in the management of my disorder.

I have received a temporary and/or custom oral appliance for obstructive sleep apnea. I understand that the oral appliance is warranted to be free from defects in material and workmanship for a period specified by the manufacturer.

____ ____ / ____ / ________

Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) Date (mm/dd/yyyy)

____ ____ / ____ / ________

Consent Obtained, Explained and Witnessed By Date (mm/dd/yyyy)

REQUEST AND CONSENT TO PHOTOGRAPHY AND/OR VIDEO RECORD:

Todd Morgan Dental Corporation may need to photograph and/or record you to document a medical condition, or to help with the diagnosis and/or treatment of a condition. Photographs and/or recordings taken for these clinical reasons do not require your written permission. Todd Morgan Dental Corporation does need your written permission to use your photographs and/or video recordings for the non-clinical reasons below.

I hereby authorize the Todd Morgan Dental Corporation to photograph and/or video record me for the following purposes: Check YES or NO.

		YES	NO
1.)	For the advancement of not-for-profit medical purposes, including teaching, research and education.	☐	☐
2.)	For external not-for-profit educational purposes outside Todd Morgan Dental Corporation such as lectures and presentations at professional conferences.	☐	☐

I consent to photographs and/or video recordings under the following conditions:

- Copies of the photos, videos, and/ or films may be released to me if I ask for them
- I can refuse to have photos and/or video taken without any change in my medical care
- I understand and agree that although my name will not be used, it may be possible to identify me from a photo and/or video

Revoking Permission: This authorization has no expiration date; but I may revoke it at any time by writing to Todd Morgan Dental Corporation at the address below. I must state in writing that I no longer give consent for photo(s) and/or video(s) or for the use of any photo(s) or video(s) that were already taken.

______________________________________ _____ / _____ / _________

Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) Date (mm/dd/yyyy)

____

Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)

Relationship: ☐ Spouse ☐ Parent ☐ Next of Kin ☐ Legal Guardian ☐ DPOA for Healthcare

______________________________ _____ / _____ / _________ ______________ A.M. / P.M.

Consent Obtained, Explained and Witnessed By Date (mm/dd/yyyy) Time

Todd Morgan Dental Corporation
4420 Hotel Circle Court, Suite 240
San Diego, CA 92108
Phone: (619) 299 - 6299
Fax: (619) 299 - 6222

BENEFITS AUTHORIZATION:

____
Patient Name

____
Equipment

1.) HIPAA PRIVACY NOTICE (See Inserted)

2.) RELEASE OF INFORMATION
I hereby authorize release to Todd Morgan Dental Corporation and Sleep Data any and all of my medical records pertaining to my medical history, services rendered, or treatments received from my physician(s) or hospital. In order to process insurance claims, I also hereby authorize Todd Morgan Dental Corporation to furnish to my insurance carrier(s), any medical history, services rendered, or treatment needed.

3.) ASSIGNMENT OF BENEFITS
I authorize direct payment of insurance benefits by my insurance company to Todd Morgan Dental Corporation for medical supplies and/or services provided by Todd Morgan Dental Corporation (or other corporate affiliates). I authorize any holder of medical information about me to be released to Todd Morgan Dental Corporation (or corporate affiliates), my physician, or my insurance company in order to determine or secure eligibility information and/or reimbursement for covered services.

4.) FINANCIAL RESPONSIBILITY
I understand that I am responsible to Todd Morgan Dental Corporation for all charges not covered by my insurance. I recognize that in the event that my insurance company, employer, or any other third party payer refuses to pay, or delays payment beyond 90 days of my receipt of items, or in the event that I have no insurance coverage or third party payer, that I will be responsible for said payments and will make prompt reimbursement within 30 days of notification by Todd Morgan Dental Corporation for all charges.

I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE AUTHORIZATION.

____ _____ / _____ / ________
Patient / Guardian Signature Date (mm/dd/yyyy)