Document 2: Authorisation

Please take note: A divorced parent, who is not responsible for the account, should not complete the forms. The person responsible for the account has to complete this form.

I agree to and understand the following in full:

1. There are certain disabilities/illnesses that can/may affect the prognosis/success of orthodontic treatment. These may be of a generic, chronic or acute nature. Please fill out your medical history on the back of your patient's file completely and inform the Orthodontist of any underlying, acute or chronic ailments, however unimportant they might seem to you. These ailments may be existing ailments or can develop during treatment. It is the responsibility of the patient/parent to keep us up to date with his/her medical history.

2. I am lawfully entitled to act on behalf of this patient/minor. If not the lawful patient or guardian, I undertake to deliver this document in person to the lawful parent/guardian before the next appointment due.

3. I have been informed about the different treatment options and I understand it fully.

4. I have been enlightened about the possible complications that may occur during/after orthodontic treatment.

5. I acknowledge that it is my sole responsibility to question any proposed action/treatment planned by the Orthodontist should I not be completely satisfied or feel I am misinformed.

6. I agree to the fact that I have the right to a second opinion, should I have doubts about any proposed treatment/action undertaken by the Orthodontist.

7. I agree that my/my child's records may be used for educational purposes to enlighten other dentists/students/patients.

8. The Orthodontist cannot/will not accept liability for any complications arising from the treatment, be it as a result of known/unknown/undisclosed ailments/disorders/neglect from the patient's side/

Neglect from the side of a patient/parent may include the following:

A. Patients not adhering to instructions on how to care for orthodontic appliances.
B. Not using the prescribed toothbrush, floss, mouthwash...
C. Poor oral hygiene or not following oral hygiene instructions.

D. Refusing to wear headgear, elastics, retainers, etc. as instructed by a member of the orthodontic team.
E. Eating foodstuffs not allowed while undergoing treatment, for instance, biltong, toffees, chewing gum, or any foreign objects.
F. Not keeping appointments at regular intervals as prescribed by the Orthodontist.
G. Not having regular check-ups (4-6 monthly) with his/her dentist.

I ……………………………………………………………………………………

Parent full names

……………………………………………………………………………………

Identity Number

Herewith give permission to Dr H Uÿs to continue with the treatment of

……………………………………………………………………………………

Patient's full names

and I take responsibility for any costs not covered by the medical aid fund/health care provider fund.

Physical address (not postal box) (domicilium citandi et executandi):

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The person responsible for the account chooses domicilium citandi et executandi at the abovementioned home address for the purpose of service of all processes and notices, which may be changed by a 7 (seven) day written notice by registered post.

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Signature of person responsible for account **Date/*Datum***

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Name in print