SADDLE ROCK INSTITUTE

General Information and Consent for Treatment

Saddle Rock Institute

Effective Date: November 21, 2025

Welcome to the Saddle Rock Institute. At this point in your care, no specific treatment plan has been recommended until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended surgical, medical, or diagnostic procedure to be used. You may then decide whether to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

For treatment of a minor, a legal parent or guardian must be present for all treatment, including consultation.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

Patient Identification: Saddle Rock Institute takes steps to help ensure the security of our patient's personal information. This process is done by verifying the identity of all patients during their visits

SADDLE ROCK INSTITUTE

to Saddle Rock Institute. All patients are required to present valid photo identification such as a Colorado driver's license, Colorado identification card, passport, or other government-issued photo identification at each appointment.

Interpreter Services: Saddle Rock Institute has free Interpreter Services available upon request for patients during treatment at the Saddle Rock Institute. This includes interpreter services when patients do not speak or understand English as well as for the hearing and visually impaired.

Notice of Privacy Practices: Saddle Rock Institute may release information to other entities or health care providers, for treatment, for payment of services and for health care operations as described in the “Notice of Privacy Practices.”

Scribe Service: I am aware that the physician may use a virtual scribe service called Augmedix to share a secure and encrypted recording of your visit. This scribe will create your electronic medical records in non-real time. The audio recording is stored securely by Augmedix in accordance with HIPAA guidelines and used for better medical care delivery, improved medical documentation, and quality assurance. I have also been informed that it is my choice if I want to use Augmedix in my visit with my physician. I also realize that by signing this form, I give my consent to allow the physician to use Augmedix in all my future visits. If at any time I decide to not allow Augmedix, I am to let the assistant or physician know, and the physician will not use Augmedix.

Right to Discontinue Treatment: Saddle Rock Institute has the right to discontinue care for any appropriate reason, such as excessive missed appointments, disruptive personal behavior, or lack of compliance to prescribed therapies. In such cases, the patient or patient’s representative agrees to accept full responsibility for pursuing alternate professional dental care. A letter will be sent out informing the patient of the treatment that is discontinued. All records pertaining to treatment and diagnosis are a property of Saddle Rock Institute. Records and x-rays may be duplicated upon written request with a reasonable charge. If care is discontinued, Saddle Rock Institute will provide emergency care, on a fee-for-service basis, for 45 days from the date of the discontinue notice.

SADDLE ROCK INSTITUTE

I have had an opportunity to ask questions about any policies of Saddle Rock Institute. These questions have been answered to my complete satisfaction.

I have given an accurate reporting of my medical, mental, and dental health issues.

I consent to the taking of photographs, slides, videotapes, models, intraoral scans, and x-rays of my oral and facial structures and the collection of my extracted teeth. I also consent to the use of de-identified patient information, photographs, slides, videotapes, models, intraoral scans, x-rays of my oral and facial structures and extracted teeth, for publication, education, and scientific purposes.

I give permission to Saddle Rock Institute to send copies of my medical and dental records, including radiographs, to the referring dentist or physician when requested.

I give permission for the Saddle Rock Institute to contact me using email, text and phone notifications to remind me of the date and time of my appointment and other appointment information. I give permission for Saddle Rock Institute to leave detailed voice messages about my care, to answer questions, and financial/billing information. By providing my phone number, I consent to receive text messages from Birdeye to review our services. I may opt out from receiving notifications at any time.

I understand that if a prescription is written for a controlled substance, state law requires that certain prescription information, including my name, be entered into a secure database (Colorado's prescription drug monitoring program) when I fill this prescription at my pharmacy. Authorized prescribers of controlled substances and law enforcement, in limited circumstances, may access the database for allowed uses.

SADDLE ROCK INSTITUTE

I understand all of the above patient information contained on this document and agree to abide by all of the procedures and conditions specified. I hereby give permission for diagnosis and /or treatment at the Saddle Rock Institute for myself or for the minor child or dependent named in this document. I voluntarily request a physician, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

COVID-19 Informed Consent Form Addendum Practice

You are currently receiving treatment from Saddle Rock Institute. In addition to the benefits and risks of treatment outlined in Saddle Rock Institute's informed consent form, and as discussed with you, all those receiving any form of treatment are at an increased risk of becoming infected with coronavirus (also known as "COVID-19"). It is important that you understand this and you may ask questions at any time. Saddle Rock Institute is taking recommended precautions to avoid transmission of COVID-19 by and between their employees and patients and as outlined in Saddle Rock Institute's COVID-19 Preparedness and Response Plan. However, while these precautions lower your risk of infection with COVID-19, even with these precautions you may become infected. By consenting to undergo treatment you are acknowledging this risk and waiving any claims against Saddle Rock Institute for any and all damages that may result from COVID-19 infection. You acknowledge that the risks associated with COVID-19 infection range from mild cold and flu-like symptoms to death. All statements contained in the previous/concurrent informed consent form are still valid, including all potential benefits and risks, in addition to the risk of COVID-19 infection.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Sign Here

SADDLE ROCK INSTITUTE

_____

Signature of Patient or Patient's Legally Authorized Representative

_____

Printed Name of Patient