# *Informed Consent*

## Informed Consent, Release Of Liability And Assumption Of Risk For Oral Appliance Use For The Treatment Of Sleep Disordered Breathing

I understand that I have been diagnosed by my physician as requiring treatment for sleep-disordered breathing (snoring and/or obstructive sleep apnea). Due to the nature of sleep disordered breathing, failure to comply with the treatment can result in severe physical and social issues including but not limited to: coronary artery disease; stroke; congestive heart failure; atrial fibrillation; diabetes; increased motor vehicle accidents; hypertension; excessive sleepiness; and increased mortality.

Oral appliance therapy for snoring/obstructive sleep apnea assists breathing during sleep by keeping the tongue and jaw in a forward position during sleep. Oral appliance therapy has effectively treated many patients. However, there are no guarantees that it will be effective for you, since everyone is different and there are many factors that influence the upper airway during sleep. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time, you may still experience the symptoms related to your sleep disordered breathing. If you are medically diagnosed as having sleep apnea, a follow-up sleep study to objectively assure effective treatment using the oral appliance should be obtained.

Published studies show that short-term side effects of oral appliance use may include excessive salivation, difficulty swallowing with the appliance in place, sore jaws, sore teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth and short-term bite changes. There are also reports of the dislodgement of ill-fitting dental restorations. Most of those side effects are minor and resolve quickly on their own or with minor adjustment of the appliance. Long-term complications include bite changes that may be permanent that result from tooth movement and/or jaw joint repositioning. These complications may or may not be fully reversible once appliance therapy is discontinued. If not, restorative treatment or orthodontic intervention for which you will be responsible may be suggested in certain cases.

Follow-up visits with the provider of your oral appliance are mandatory to ensure proper fit and to allow an examination of your mouth to assure a healthy condition If unusual symptoms or discomfort occur outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further.

As Crossings Clinic Dental Sleep Apnea Center cannot ensure success of any type of therapy and cannot guarantee that any patient will comply with the treatment for sleep apnea, I hereby waive any rights that I, my heirs and assigns might have to seek legal redress for any damage, physical or monetary, that I might sustain as a result of my treatment for sleep apnea or any failure on my part to comply with treatment.

Therefore, I release Crossings Clinic Dental Sleep Apnea Center, and their staff; from any and all liability associated with my treatment and I personally assume all risks associated with my care, including, but not limited to: coronary artery disease; stroke; congestive heart failure; atrial fibrillation; diabetes; increased motor vehicle accidents; increased work place accidents; hypertension; excessive sleepiness; TMJ disease; periodontal disease and increased mortality.

Other accepted treatments for sleep-disordered breathing include behavioral modifications, positive airway pressure and various surgeries. It is your decision to have chosen oral appliance therapy to treat your sleep disordered breathing and you are aware that it may not be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to this provider's office. Failure to treat sleep-disordered breathing may increase the likelihood of significant medical complications.

I have received, read and understand the conditions and information in this informed consent. I have had the opportunity to discuss the foregoing conditions and the information concerning the oral appliance. Furthermore, I give my permission for my diagnostic and treatment records to be used for the purposes of research, education or publication in professional journals. I also accept financial responsibility for this therapy. With all of the foregoing in mind, I authorize treatment and confirm that I have received a copy of this consent form.

Patient Name (Please print) _____

Patient Signature _____

Date _____