UNIVERSITY OF NEW ENGLAND
WESTBROOK COLLEGE
OF HEALTH PROFESSIONS
Department of Dental Hygiene

Patient's Rights and Responsibilities

Dental hygiene care in this institution is patient-centered and therefore focuses on the well-being of our patients. This statement is included to communicate and advocate the expressed wants and needs of our patients and to help the provider-patient relationship to realize excellence in care.

Patients can expect:

1. To be treated with respect, consideration, confidentiality and to uphold privacy.
2. A thorough assessment of their current needs, by student hygienists.
3. To be informed of appointment and fee schedules in advance.
4. To receive an explanation of recommended treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment, and expected outcomes of various treatments, to make an informed consent before any treatment is begun.
5. To receive treatment that meets the standard of care in the profession of dental hygiene.
6. To receive appropriate and timely referrals for other needed services.
7. Continuity and completeness of care.

Patients are expected to:

1. To cooperate as partners in their care by asking for information and clarification, and to participate in goal setting and planning of treatment.
2. Comply with recommended or agreed upon therapies or actions of care.
3. Accommodate student learning needs by returning for further appointments, if required.
4. UNE Dental Hygiene Clinic is an educational institute and patient may be dismissed at any time if patient is counterproductive to student learning.
5. Attempt to keep scheduled appointments, so that student learning and patient care may proceed.
6. Recognize that care received by dental hygiene students under the supervision of qualified faculty is dental hygiene care. Any restorative or emergency dental care will require the expertise of a licensed dentist in your community.

Having read the above, I verify that I understand the information contained there-in, and I grant the authority to the UNE –College of Health Professions, Dental Hygiene Clinic to perform dental hygiene treatment procedures deemed necessary for me.

_____
Patient's Full Name (Print)

_____ _____
Patient's Signature or Responsible Adult Date

I also agree to make payment for services in accordance with my treatment.

_____
If responsible adult, what is your name and relationship to the dependent?

_____
Address, City, State, Zip