**Consent for Candid Clear Aligners**

# Welcome to Candid® Clear Aligners

Please read and follow these instructions to support the success of your Candid® Treatment

Patient First Name: Patient Last Name: DOB:

Your doctor has recommended Candid® clear aligners for your orthodontic treatment. Treatment with Candid® clear aligners, like any orthodontic treatment, may carry some of the potential risks and inconveniences listed below, among others. Please read the following information and make sure that you ask any questions or raise any concerns you may have before signing the Consent Form.

Getting Started:

1. Your first goal is to get used to wearing your aligners. During treatment, you will wear your aligners full time, except while eating and drinking for at least 22 hours per day. 2. The sooner you begin to wear your aligners for at least 22 hours per day, the sooner your teeth will begin to move and you will become accustomed to speaking with the aligners in place. Speaking, reading and/or singing out loud with your aligners in place will improve your speech much sooner. 3. Remove your aligners only to eat, drink, and clean your teeth by flossing and brushing them. 4. You may drink room temperature or colder water while wearing your aligners, but nothing else. DO NOT EAT OR DRINK ANYTHING EXCEPT WATER WHILE WEARING YOUR ALIGNERS. 5. Eating or drinking while wearing aligners will stain and damage the aligners in addition to encouraging tooth decay and gum disease.

POTENTIAL RISKS OF TREATMENT

Complying with your doctor’s instructions for use of the aligners is essential for the success of your treatment. Failing to use the aligners for the prescribed time periods, missing appointments or scans through the Candid App remote monitoring may interfere with the results and length of your treatment. A patient’s specific dentition, including uncommon tooth shape, and other anomalies encountered during treatment may also impact treatment results. Failure to follow your doctor’s instructions for oral hygiene during treatment may result in decay, gum irritation, tissue disease or permanent discoloration of teeth. Some discomfort when switching aligners during treatment may occur. Patients may experience irritation to gums, cheeks or lips during treatment. The aligners may temporarily affect speech and may result in a lisp that typically disappears within one or two weeks. Aligners may cause a temporary increase in salivation or mouth dryness and certain medications can heighten this effect. Notify your doctor of any medical conditions/medications as they could affect treatment. Allergic reactions are also possible and should be reported to your doctor. In some cases, additional treatment appliances may be required for treatment plans and may be prescribed by your doctor. Dental implants cannot be moved by aligners. Additionally, existing restorations may require repositioning or replacement as the result of treatment, which may require additional dental, surgical or endodontic treatment. In extreme cases, teeth may be lost. Orthodontic appliances can be swallowed or aspirated, particularly following breakage. Any breakage or looseness of appliances used during treatment should be immediately reported to your doctor. Teeth may shift after treatment is completed. Wearing retainers post-treatment, as prescribed by your doctor, is essential to maintaining achieved results. My doctor may use the Candid App dental monitoring app to supervise the progress of my treatment remotely. Because of these and other unforeseen factors that may affect your treatment, treatment results cannot be guaranteed. Some cases may require refinements with additional clear aligners, traditional orthodontic techniques, and other cosmetic procedures to achieve ideal results.

Candid® Aligner Treatment Consent Form

Orthodontics is not an exact science, and I acknowledge that Candid Care Co. ("Candid") and my doctor have not and cannot make any guarantee or provide any other assurances regarding the outcome of any treatment. I understand that Candid® is not a provider of medical, dental or health care services and does not and cannot practice medicine, dentistry or give any medical advice. All clinical and treatment decisions affecting my treatment will be made by my doctor. In signing this Consent Form, I am indicating that I understand the risks or options available for orthodontic treatment. Any concerns or questions that I may have had were sufficiently explained or answered by my doctor and I consent to treatment for myself or a minor under my legal care. I also agree that the doctor may provide medical records, including but not limited to, x-rays, reports, charts, medical history, photographs, findings, dental plaster models or impressions, diagnosis, prescriptions, testing and results, billing or any other records regarding treatment and in my doctor’s possession relating to me or a minor under my care (collectively “Records”) to Candid® or other licensed dentists or orthodontists. I also understand that any use of my medical records may result in the disclosure of my or my minor’s “individually identifiable health information” as defined by the Health Portability and Accountability Act (“HIPAA”). I will not, nor anyone acting on my behalf or on behalf of my minor, seek legal, equitable or monetary damages or remedies for such disclosure. I understand that no compensation will be provided for use of my Records, which is without compensation. I acknowledge that I as well as anyone on my behalf shall not have any right of approval, claim of compensation or right to seek legal, equitable or monetary damages or remedies resulting from any use or disclosure permitted under the terms of this Consent Form. I consent to the use of the Candid App dental monitoring app for the remote supervision of my treatment or the treatment of the minor under my care. I agree that I have read, understand and agree to terms stated in this Consent Form as indicated by my signature below; a photostatic copy of this Consent Form will be regarded as effective and valid as an original.

Signature of Patient, Parent, Guardian or Personal Representative:

Sign

Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient: