advance and is non-refundable at any stage of the treatment, even if the patient did not complete the treatment for any reason whatsoever.

Signing this paper by the patient or any who is responsible for him/her or represents him/her means that:
He/she has read the paper and understood its contents, and has questioned in a full and satisfactory manner about everything related to the treatment from the doctors of the clinic and any other party they want to consult, and that the patient has approved what was explained to them and requested the physicians of Dentistree Dental Clinic to begin the treatment and gave them the authority to do whatever they consider is appropriate for his/her case, and pledged to follow their instructions, attend all the treatment sessions on time and pay the treatment cost in full.He/she has read the paper and understood its contents, and has questioned in a full and satisfactory manner about everything related to the treatment from the doctors of the clinic and any other party they want to consult, and that the patient has approved what was explained to them and requested the physicians of Dentistree Dental Clinic to begin the treatment and gave them the authority to do whatever they consider is appropriate for his/her case, and pledged to follow their instructions, attend all the treatment sessions on time and pay the treatment cost in full.

I have read all what is mentioned above and I will sign below in agreement on it.

I agree that healthcare provider(s) involved in my care at this facility will access my healthinformation through the Health Information Exchange System (NABIDH) in accordance with the Lawsof the United Arab Emirates, Emirate of Dubai Legislation and Dubai Health Authority Policies.

قدمي) الرعاية الصحية المشاركين في رعايتي في هذه المنشأة
ل إلى صحتي المعلومات من خلال نظام تبادل المعلومات الصحية
انين دولة الإمارات العربية المتحدة، تشريعات إمارة دبي وسياسات

Sign here, only if all of your questions have been answered to your satisfaction

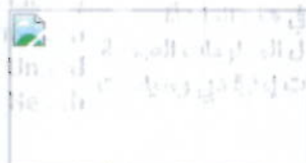
Hamza Ismail Saeed

2:

Patient's name **Signature of Patient Legally authorized Representative** **D**

2:

Witness Signature



D

Chahita Lalchandani

2:

Dentist's Signature **D**