Dental Implant Aesthetic Center

RELEASE OF INFORMATION

I authorize the Dental Implant Aesthetic Center to discuss medical/financial information relating to my treatment to the following individuals:

Name ______________________________ Relationship to Patient ______________

Name ______________________________ Relationship to Patient ______________

X ______________________________ ______________

Signature (patient or parent/guardian if minor child) Date

FINANCIAL POLICY

If you do not have insurance to cover the charges incurred, we expect payment in full when services are rendered. If you have insurance to cover your charges, we will file directly to your insurance company for any charges incurred during your visit, but co-payments and coinsurance payments are expected when services are rendered. It is our office policy not to file secondary insurance, though we will provide you with the necessary information to file a claim. Please be advised that we estimate your insurance benefits based on the information your insurance company provides. The actual amount you owe after insurance pays could be more or less than the original estimate. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS AND ANY RESTRICTIONS YOUR PLAN MAY HAVE. We must emphasize that as an dental practice, our relationship is with you, not your insurance company.

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number I provide, 2) any email address that I provide, 3) auto dialer system, 4) voicemail messages, and other forms of communications.

Returned checks and balances over 90 days are subject to an additional collection fee as follows: $25.00 for balances under $500.00 and 10% for balances over $500.00. If you have any questions, please do not hesitate to speak to the office staff.

I have read the foregoing and understand that I am responsible for payment of all services rendered, regardless of insurance coverage or other third party liability. I agree to pay all cost of collection, including reasonable attorney fees and court costs in the event it becomes necessary to pursue the account for collection.

X ______________________________ ______________

Signature (patient or parent/guardian if minor child) Date

PHOTOGRAPHIC RELEASE

It is our office policy to take photos of every new patient for documentation purposes; we will not use these photos for publication without your signed consent below.

I agree that the Dental Implant Aesthetic Center may use such photographs and/or reproductions of those images of me, my face, and my teeth without my name for such purposes of publish in print, as well as documentation and study.

☐ I am **GRANTING** the Dental Implant Aesthetic Center permission to use my photos for marketing purposes

☐ I am **DENYING** the Dental Implant Aesthetic Center permission to use my photos for marketing purposes

X ______________________________ ______________

Signature (patient or parent/guardian if minor child) Date