DATE ______ / _____ / _______

# ACKNOWLEDGEMENT OF OFFICE POLICIES

**Patient Name:**_____________________________________

________ *Initial*

**FINANCIAL RESPONSIBILITY:** I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due at the time services are rendered unless financial arrangements have been made. I understand any debt not paid within 90 days will be sent to collections and I will be responsible for all collections and legal fees related to that debt. I understand I am responsible for all charges for services whether or not paid by insurance. I authorize Westmoore Dental Studio ("the office") to disclose all information necessary to verify my dental and medical insurance eligibility.

________ *Initial*

**ASSIGNMENT OF BENEFITS:** I hereby assign all dental and medical benefits to which I am entitled. I authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Westmoore Dental Studio. I understand that any payment made directly to me by my dental and/or medical carrier will be immediately transferred to the office.

________ *Initial*

**PRIOR EXPRESS CONSENT FOR CALLS/TEXTS/EMAILS:** By providing the number of my land line or cell phone and my email address now or in the future, I expressly consent and agree that the office may call me using an automated system or otherwise, leave me a voice message, send me a text, and/or send me an email related to dental appointments and/or account. I agree that Westmoore Dental Studio may monitor and record any telephone calls to assure the quality of its service or for other reasons. I can opt out of emails and texts at any time by contacting the office.

**Home:**________________________________ **Cell:**________________________________________

**Email:**_____________________________________________________________________________

________ *Initial*

**PHOTOGRAPHY / VIDEO IMAGES:** Westmoore Dental Studio will be using electronic medical records, including your photograph, to maintain your health care information. The office may also authorize the use and disclosure of my name, photograph/video images and/or testimonials for marketing purposes by Westmoore Dental Studio. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations. I may withdraw this consent by submitting a written notice to Westmoore Dental Studio. We will never sell your information to a third party.

________**YES** - I agree to have my photo taken and stored in the office's electronic medical system.

________**YES** - I agree to have my photos/videos/testimonials used for social media and/or advertising efforts.

________**NO** – I do not wish to have my photo/video/testimonial used for social media and/or advertising efforts.

## I have read and understand Westmoore Dental Studio's Office Policies.

**Patient Signature:**____________________________________________________________________

**Or**

**Responsible Party Signature:**_____________________________________ **Relation to Patient:**_________________