

**Financial Agreement**

**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Thank you for selecting Nathan E. Robison DDS, MDS (West Dental Implants & Prosthetics) for your dental care services.

You have been/will be given a treatment estimate detailing your estimated portion for any/all prescribed dental work.

Please note that this estimate may be subject to change.

West Dental Implants & Prosthetics is not an in-network insurance provider for any insurance company.

We expect payment in full at the time of service regardless of your insurance benefits.

 As a courtesy to our patients with insurance, we will submit a claim to your insurance company on your behalf.

Also, as a courtesy to our patients, we will submit a pre-determination to your insurance company if you would like to know the amount

that insurance will reimburse you for treatment that has been planned.

We accept all major credit cards as well as check or cash.

Any services rendered over $1000 in a single visit are eligible for a 5% discount if paid in full with cash or check only.

If financial assistance is needed to pay for services, we will assist you in developing a financial plan with the following entities:

CareCredit, Proceed Finance, and DOCPAY. If these options are unacceptable, then you are responsible for your own financial arrangements.

Initial the following:

\_\_\_\_\_ I agree to be financially responsible for payment of West Dental Implants & Prosthetics services.

Delinquent accounts will be sent to collections. If your account is in a state of delinquency, dental services will be postponed until account is in good standing.

\_\_\_\_\_ I understand and accept that I will be assessed a $50 fee if I fail to keep my scheduled appointment or fail to cancel my scheduled appointment within 1 business day. I also understand that to reschedule my appointment, this $50 payment MUST be paid.

\_\_\_\_\_ I acknowledge if I cancel an appointment scheduled for more than 1 hour, or exceeds $2000, I will be required to make a NONREFUNDABLE 10% down payment of the total cost of the procedure to reschedule the appointment.

\_\_\_\_\_ I understand that if I no show, or cancel two consecutive appointments without warning, I will be dismissed from the practice.

\_\_\_\_\_ I understand that payment is due when services are rendered (except for pre-arranged payment plans).

\_\_\_\_\_ I acknowledge that regardless of my insurance benefits, I am responsible for payment due at time of service.

I understand that I will be kept informed of any necessary changes and acknowledge that I will be financially responsible for any such changes.

 Please acknowledge your understanding and willingness to comply with the above agreement.

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**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED**

**AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**Please read until the end to sign the document**

**YOUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this “Notice” about our privacy practices, our legal duties, and your rights concerning your health Information. We must follow the privacy practices that are described in this “Notice” while it is in effect. This “Notice” takes effect April 14, 2003 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this “Notice” at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our “Notice” effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this “Notice” and make

the new “Notice” available upon request. You may request a copy of our “Notice” at any time. For more information about our privacy practices, or for additional copies of this “Notice”, Please contact us using the Information listed at the end of this “Notice.”

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**PAYMENT**: We may use and disclose your health information to obtain payment for services we provide to you.

**HEALTHCARE OPERATIONS**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**YOUR AUTHORIZATION**: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while It was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this “Notice.”

**TO YOUR FAMILY AND FRIENDS**: We must disclose your health information to you, as described in the Patient Rights section of this “Notice”. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care of with payment for your healthcare, but only if you agree that we may do so.

**PERSONS INVOLVED IN CARE**: We may use or disclose health information to notify

or assist in the notification of (including identifying or locating} a family member, your personal representative

or another person responsible for your care of your location,

your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare.

We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**MARKETING HEALTH-RELATED SERVICES**: We will not use your health information for marketing communications without your written authorization, that is directly relevant to the person’s involvement in your healthcare.

We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**MARKETING HEALTH-RELATED SERVICES**: We will not use your health information for marketing communications without your written authorization.

**REQUIRED BY LAW:** We may use or disclose your health information when we are required to do so by law.

**ABUSE OR NEGLECT**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent of necessary to avert a serious threat to your health or safety or safety of others.

**NATIONAL SECURITY**: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials’ health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**APPOINTMENT REMINDERS**: We may use or disclose your health Information to provide you with appointment reminders (such as voicemail messages, text messages, emails, or letters).

**PATIENT RIGHTS**

**ACCESS:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this “Notice”. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this “Notice”. If you request copies, we will charge you 10 cents for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us by using the information listed at the end of this “Notice” for a full explanation of our fee structure.

**DISCLOSURE ACCOUNTING**: You have a right to receive a list of instances in which we or our business associates disclosed your health Information for purposes other than treatment, payment, healthcare operations, and certain other activities for the last 6 years but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

**RESTRICTION**: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**ALTERNATIVE COMMUNICATION**: You have the right to request that we communicate with you about your health Information by alternative means or to alternative locations. You must make your request in writing.

Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**AMENDMENT**: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

**ELECTRONIC NOTICE**: If you receive this “Notice” on our website or by electronic mail (email), you are entitled to receive this “Notice” in written form.

**QUESTIONS AND COMPLAINTS**: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made to access your health information in response to a request you made to amend or restrict the use or disclosure of your health Information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this “Notice”. You also may submit a written complain to the U.S. Department of Health and Human services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health Information.

We will not retaliate in any way if you choose to file a complaint with us or with the U. S Department of Health and

Human Services.

Contact Officer: Nathan Robison

Phone: 970-259-5600 Fax: 970-247-2820

Address: 2323 W 2nd Avenue, Durango, CO 8130

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices.

I understand that I am giving my permission to your use and disclosure of my protected health information

in order to carry out treatment, payment activities, and healthcare operations.

I also understand that I have the right to revoke permission.

Phone: 970-259-5600 Fax: 970-247-2820

Address: 2323 W 2nd Avenue, Durango, CO 8130

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices.

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X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Information

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| We are please to welcome you to our office. Pease take a few minutes to fill out thisform as completely as you can. If you have any questions, we’ll be glad to help you. |

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| Personal |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Preferred)M.FirstLastBirthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: [ ] M [ ] F Married: Y [ ] N [ ]Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wireless Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Contact Method [ ] HmPhone [ ] WkPhone [ ] WirlessPh [ ]EmailPreferred Contact Method for Confirmations [ ] HmPhone [ ] WkPhone [ ] WirlessPh [ ]EmailPreferred Contact Method for Recall [ ] HmPhone [ ] WkPhone [ ] WirlessPh [ ]EmailStudent status if dependent over 19 (for Ins) [ ] Nonstudent [ ] Fulltime [ ] ParttimeHow did you hear about us?(If someone referred you here, please write down their name so we can thank them.) |
| Address and Home Phone |
| Check box if same for entire family [ ]Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insurance Policy |
| Your Relationship to subscriber: [ ] Self [ ] Spouse [ ] ChildSubscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please present insurance card to receptionist |
| Insurance Policy |
| Your Relationship to subscriber: [ ] Self [ ] Spouse [ ] ChildSubscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please present insurance card to receptionist |

Comments:

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Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following medical conditions?

Y N Y N

Diabetes Tobacco Use (if yes see below):

Periodontitis If yes, what kind and how much?

Osteoporosis/Osteopenia Endocrine Disease

Asthma Lung Disease

Epilepsy HIV/AIDS

Thyroid Disease Ulcers

Tuberculosis Bleeding Disorder

Hepatitis (A, B, C, D) Hypertension

Heart Disease Cancer

Heart Murmur Rheumatic Fever

Angina Liver Disease

Glaucoma Stroke

Joint Replacement

Are you currently taking any blood thinners?

If Yes, what medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, do you need to pre-medidcate before dental procedures?

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List of Current Medications:

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Have you or are you taking any of the following:

Y N Y N

 Denosumab (Prolia) Zoledronic (Reclast)

Y N Y N

Alendronate (Fosamax) Risedronate (Actonel)

 Ibandronate (Boniva)

 (Women) Are you currently pregnant?

 Do you have any allergies to medications?

 If yes, what medication(s)?

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 Do you have any medical issues not mentioned?

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Do you have chronic pain?

 If yes, what is the name of the doctor managing your chronic pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications to manage your chronic pain?

If so, what are they?

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Dental Information

Name of General Dentisit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your dental concerns?

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Unusual reaction to dental injections?

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Additional Comments:

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**Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images**

**Authorization:**

I, ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize ﻿Dr Nathan Robison to take and/or reproduce photographs/video of my teeth or face for publications, presentations, patient testimonials, smile gallery and marketing materials to be used online, social media and/or website.

**CONSENT**

I acknowledge I have read and understand the above consent. I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. By signing below, I understand and agree that photographs and videos may be taken of me for educational and marketing purposes. I release ﻿Dr Nathan Robison from any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

**Revocability:**

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

**No Treatment Conditions:**

I understand that the practice cannot condition treatment on whether or not I sign this authorization.

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**