SPECIALISTS IN IMPLANT DENTISTRY

Financial/Insurance Policy

Payment is due at the time of service

I understand that Specialists in Implant Dentistry is an out-of-network provider and that they do not accept assignment (payment) directly from my insurance company. They will submit claims to my insurance company as a courtesy to me. Any applicable payments from my insurance company will come directly to me. If a pre-treatment estimate is obtained, I understand that it is NOT a guarantee of payment. By signing below, I understand that I am responsible for this account, and that payment for treatment is due at time of service

SIGNATURE **PRINT NAME** **DATE**

Patient's Name: ______________________________ **Subscriber's Name:** ______________________________

Insurance Company: ___________________________ **Subscriber's DOB:** ______________________________

Subscriber ID or Social Security Number: ____

SPECIALISTS IN IMPLANT DENTISTRY

Image Consent Form

I consent that my photograph or likeness (the "Images") and the entire text of, excerpts from, or a part of any letters, e-mails or other communications I have sent to Implant and Restorative Dentistry of South Florida, d/b/a Specialists In Implant Dentistry (the "Practice"), or any of its dentists or other personnel (the "Communications"), may be used by the Practice under the following conditions.

The Images, negative, prints or copies thereof and the Communications may be used for educational, dental, marketing and promotional purposes for the Practice and its services, and its dentists. They may be published and republished either separately or in connection with each other, on websites, in magazines, newspapers, or other periodicals, television or other marketing and promotional materials of the Practice, or used for any lawful purpose that the Practice may deem appropriate.

I understand that the Images may be modified or retouched in any way that the Practice, in its discretion, may consider desirable, and that portions or excerpts of the Communication for use by the Practice may be determined as the Practice deems appropriate.

I understand that the Images and Communications received by the Practice are and will remain the exclusive property of the Practice and I will have not right, title, or interest in them whatsoever.

By consenting to the use of the Images and the Communications as set forth above, I understand that I will not receive payment from any party. I understand that refusal to consent to use the Images and the Communication will in no way affect the dental care I will receive.

ACCEPT DECLINE

SIGNATURE **PRINT NAME** **DATE**

SIGNATURE OF WITNESS **NAME OF WITNESS** **DATE**