Authorization for Use or Disclosure of Patient Photographic and/or Video images

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising and for doctor treatment planning

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.

If desired, copy provided:

○ Yes, I would like a copy of this form."
(Initialed by team member, copy provided by_______________)

Patient Name:

Date: ________________________________

Signature: ____________________________

If Patient is a Minor

Parent / Legal Guardian: ________________

Date: _________________________________

Signature: _____________________________

If Personal Representative

Name: ________________________________

Date: _________________________________

Signature: _____________________________

Relationship to Patient:__________________

This form is provided by **Stamford Dental Group, LLC** for general convenience purposes and does not represent legal advice. Additional compliance rules vary from state to state, country to country. If you feel like you need legal consultation in addition to what we've provided, be sure to consult your practice attorney including seeking advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services regulations.

Office Policy

Stamford Dental Group, LLC

47 Oak Street
2nd Floor
Stamford, CT 06905

What we expect from you as our patient and what you can expect from us you oral healthcare provider…

Thank you for choosing Stamford Dental Group as your dental providers, our purpose is to provide the highest quality of dental care in a caring atmosphere while treating patients with dignity. We will respect you and you time. You can expect professional behavior from our staff, and the highest quality of care from our providers.

If we accept you as a patient in our office we ask that you treat our staff with respect and act in a courteous and civil manner. The purpose of this policy is to provide specific guidance about our office's expectations of patient behavior in the professional environment.

Your commitment to treatment is essential to ensure the best possible outcome. Because of the level of service we provide our patients, your appointment is especially held just for you, so that we have the right amount of time for your procedure at our office. We strive to see all patients on time, and request that you extend the same courtesy to us. We ask that you are on time for your appointments. If you arrive 15 minutes late, you may be asked to reschedule for the next available appointment time.

Missed appointments:

We make every effort to confirm scheduled appointments through email, text message, and phone calls**. Patients who do not show up for an appointment, or cancel with less than 48 hour notice will be charged a $75 dollar fee.** Our answering machine is available for messages left after business hours. However if a message is left after business hours canceling or rescheduling a next day appointment the patient may be subject to our fee, as this is not considered adequate notice. Each missed appointment is recorded in your dental records. Three missed appointments without adequate notice may result in your dismissal from our office. You will no longer be a patient of record at our office.

Evening and Saturday Appointments Policy:

Patients scheduling an evening or Saturday appointments you are required to put a credit card on file, to reserve your appointment. Because these appointment are in high demand we ask that you make every effort not to reschedule or cancel. If appointment is not canceled or rescheduled with at least one week advance notice, a $150 fee will be charged to your credit card.

We are glad that you have chosen our office as your oral healthcare provider. At Stamford Dental Group we believe in providing and maintain a positive and communicative dentist-patient relationship. **Failure to comply with these terms may result in a dismissal from this office.**

Patient Signature: _________________________________ Date: ______________________

Print Name: ___________________________________