MEDICAL/DENTAL RECORDS
SIGNATURE ON FILE ARRANGEMENT
PAYMENT RESPONSIBILITY AGREEMENT
CONSENT FOR USE OF PATIENT IMAGES

I hereby authorize Michael D. Danner, D.D.S. (MDD, DDS throughout the rest of this document) to obtain verbal or written medical information from my physician(s) or dentist(s) as needed for the practice's care of my dental needs.

If MDD, DDS needs to refer me to another health care provider or to communicate with third parties, MDD, DDS will need the following authorization signed for the release of my records. I authorize Michael D. Danner, D.D.S. to release any and all information which the practice possesses relative to my examination findings, x-rays, and treatment to the physician, dentist, or, if needed, to the insurance carrier. I hereby authorize use of the words "Signature on File" on my forms in the space designated for my signature until I notify, by written note, that I wish to cancel the authorization. Such cancellation can be done at any time I may choose.

By signing this form, you will consent to our use and disclosure of your personal digital images that have been taken during the process of your treatment. These digital images may include full facial views, entire mouth dentition, a single tooth, or full smile. We will make every attempt to keep your anonymity.

We use digital images to compile a smile gallery for our reception room as well as to aid in future treatments of other patients. We will NOT sell any of these images. These images are also used to communicate with the Master Technician at the dental laboratory when dental restorations are being fabricated. This gives the Master Technician a great reference when personalizing cosmetic smile design.

Many of the other professionals we confer with also have the capability to receive our digital images electronically; this helps significantly with inter-professional communication. And finally, our dental software has the capacity to link the patient's images to their computerized dental file, this way we can see your smiling face anytime we check your file.

If I have dental insurance, I realize that my insurance simply provides a financial benefit on my behalf; it is not the total financial provider. Michael D. Danner, D.D.S.'s professional services are rendered to me and not to my insurance company. Michael D. Danner, D.D.S. and I will determine my dental care. My insurance carrier provides financial assistance for me and is not responsible for dictating the details of my dental care. I will elect my chosen care. **I am responsible for the total charges regardless of insurance involvement. I accept personal responsibility for any part of the fee not covered by my particular policy.** Any questions I have regarding the fee for the services tentatively planned for my dental appointments will be asked and answered before treatment begins. I accept the fact that not every detail of planned treatment can be anticipated ahead of time. Each procedure is unique and modifications are frequently needed as treatment progresses. **If I wish to make a monthly payment arrangement, I will do so with my Master Card or Visa Card. All of my unpaid balances – including insurance "slow-pays" – are assessed one and one-half percent interest per month 60 days after services have been rendered amounting to eighteen percent annually.** I understand that this interest is charged to avoid the natural tendency to pay all interest-bearing bills first then, if any money is left over, to pay the dental bill.

If I wish to avoid the interest charge on past-due insurance payments, I will take care of the balance myself and have the insurance carrier reimburse me directly. If the payment is sent to MDD, DDS, payment will be promptly forwarded to me. MDD, DDS will help me obtain timely payments of my insurance benefit, but it is my policy and my responsibility.

I certify that I have read and understand the above. Any questions about the above agreements have been answered to my satisfaction. After the form is signed, I am to receive a photocopy of this document for my records.

SIGNED _____ DATE _____

(or parent, if patient is a minor)