PHOTOGRAPH FORM

I, _____, understand Smith Dental Care will take my full-face photograph. I understand that this photograph will only be seen by employees of Smith Dental Care and me, unless otherwise authorized. **Initial** _____

Video Policy

We ask that you refrain from cellular use while in the clinical areas. For the privacy of our patients, staff, and doctors, we do not allow videos to be taken while we are treating our patients. **Initial** _____

Insurance and Financial Information

Smith Dental Care is **OUT OF NETWORK** with your dental insurance; however, we can still file on most insurance. You are responsible for any charges not covered by your insurance. Payment is expected at the time of treatment. We will gladly bill insurance as a courtesy; however, most insurance companies do not provide 100% of your payment. If for some reason your insurance company has not paid their estimated portion within 90 days from the start of treatment, you are responsible for the payment in full at that time. Smith Dental Care does utilize third party billing/collection agencies to assist in collection efforts. A $20 processing fee will be charged in addition to your past due balance if transferred to secondary phase collections.

I have read the above insurance and financial conditions and agree to its contents.

_____ Date:_____
Print Patient Name

_____ _____
Signature of Patient or Guardian Relationship to Patient

Updated: 04-12-2022