Patient Authorization to Use or Disclose Photography/Video

I authorize Green Lake Cosmetic Dentistry (Dr. Cherryl Ellison and associates) to take and or reproduce photographs/video of my teeth or face for educational material, marketing material, and/or dental lectures and presentations. Information to be used or disclosed: Photographs, video and/or electronic media.

Your privacy is important to us. This authorization for release of records will **not** release the following specially protected information: Reproductive Care (applicable to minors only), Sexually transmitted diseases, mental health, drug and alcohol treatment and/or HIV/AIDS. This authorization expires when there is a written request from the patient to terminate this authorization.

By signing this page, I acknowledge that I have read and agreed to the terms of this agreement.
Signature: _____ **Date:**_____

Missed Appointment Policy

Please note that our time is valuable and so is yours. We always strive to be on time for your reserved appointments. We require a minimum of **two office days notice** (Mon-Thurs 8AM-5PM) for any cancelled appointment, otherwise a missed appointment fee will be charged to your account.

Broken Appointment Fees: Hygiene Appointment - $50 per hour; Doctor Appointment - $100 per hour; Appointments requiring 3rd Party Services - $200 fee

By signing this page, I acknowledge that I have read and agreed to the terms of this agreement.
Signature: _____ **Date:** _____

HIPAA – Health Insurance Portability & Accountability Act

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I understand that this information can and will be used to: **1) Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly. 2) Obtain payment from third-party payers for my health care services. 3) Conduct normal health care operations such as quality assessment and improvement activities**

I have been informed of my health care provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices;* importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name:_____ Signature: _____ **Date**: _____
Relationship to Patient: _____
Dependent family members also covered by this acknowledgement: _____

- - - - - - - - - - - For Office Use Only - - - - - - - - - - - -

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following reason:

The patient refused to sign: _____ Communication Barriers: _____ Emergency Situation: _____ Other: _____