Photography Release/Consent Form

Here at ARPD, we make every effort possible to make our patients feel special. We like to put our patients on "display" by clipping newspaper articles involving our patients; as well as, pictures from any drawings or prize winnings and posting them in the office, on our Facebook page, website, or Instagram. Please check one of the following boxes and sign below.

☐ ***I AGREE*** and hereby grant full permission to Angelica Rohner Pediatric Dentistry, Dr. Angelica Rohner & Staff, to use either myself or my child /children's name(s) and photograph in any publication or advertising materials (printed or electronic). This consent also serves to waive all rights of privacy or compensation which I may have in connection with the use of my photograph and/or my child's photograph and/or name.

Be sure to follow our social media sites to see your child's smile!
www.drrohner.com
www.blogspot.com/drrohner
www.instagram.com @drrohner_kiddmd
www.facebook.com @Angelica Rohner Pediatric Dentistry

☐ ***I DO NOT AGREE*** to have mine or my child's information or photograph used for public viewing.

_____
Child/Children's Full Name(s)

_____
Legal Guardian's Name (Print) **Relationship to Child**

_____
Signature **Date**

ANGELICA ROHNER PEDIATRIC DENTISTRY
● 2045 Brookwood Medical Center Drive, Ste. 21 ● Birmingham, AL 35209 ● (205) 870-0892 ●

Angelica Rohner
Pediatric Dentistry
Caring For Each Child Like Our Own

APPOINTMENT POLICY

Valuable time has been reserved for your child's dental care. A missed appointment results in lost time which prohibits another patient waiting to receive treatment from doing so. We make every effort to stay on schedule so we respectfully ask patients to be prompt and keep their appointments. Our standard appointment policy is as follows:

COURTESY CONFIRMATION

We will attempt to contact you either by phone, text or email prior to your scheduled appointment. This is to confirm with you the day and time reserved for your child.

24 HOUR NOTICE

If you must cancel your child's appointment, please call our office *at least* 24 hours in advance. A 24 hour notice is required to cancel or change an appointment. A $25.00 fee, uncovered by your insurance, may be charged to your account if the appointment is missed, cancelled or rescheduled without 24 hours' notice.

Exceptions to this policy can be determined only on an individual basis, according to the circumstances. We understand that, occasionally, children's illness or other unexpected emergencies make it necessary to cancel an appointment with less than 24 hours' notice. Please contact our office immediately and we will do our best to accommodate your situation.

LATE ARRIVALS

If you arrive more than 10 minutes late to your appointment, you may be asked to reschedule. Contingent upon the day's schedule, you may be able to be worked in. If you agree to do so you must wait until an appointment time is available or another patient cancels. *We thank you in advance for your understanding and cooperation.*

We ensure you that following all of the above policies will allow us to serve you and your child better.

***By signing below I hereby acknowledge receipt of the Angelica Rohner Pediatric Dentistry, DMD, PA's Appointment Policy.

Responsible Party Signature _____ **Date** _____

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FINANCIAL POLICY

Mandated Policy Update October 2017

Thank you for choosing Angelica R. Rohner, DMD, P.A. for your child's dental care. We want to establish a long and pleasant relationship with you and your child. Just as we are committed to providing excellent pediatric dental care, we also strive to make it affordable to you. Please read the below financial agreement.

DR. ROHNER IS CURRENTLY A PROVIDER WITH THE FOLLOWING INSURANCE COMPANIES:

- *Southland National Insurance Company*
- *Blue Cross and Blue Shield of Alabama*
- *Cigna Dental, PPO*
- *Delta Dental*
- *Guardian*
- *MetLife*

PLEASE UNDERSTAND that we file dental insurance *as a courtesy to our patients*. We do not have a contract for you with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on your behalf. Most plans only cover a portion of the dental fee, which means you will be responsible for your deductible and the estimated portion at the time services are rendered. We can only estimate your coverage in good faith. We at no time guarantee what your insurance will or will not cover. As a service to our patients, we will bill your insurance company for services and allow them 45 days to render payment. After 45 days, you are responsible for the entire balance, paid in full. If you have any questions, please feel free to speak with our Practice Administrator.

IF YOUR INSURANCE IS NOT WITH ONE THE ABOVE COMPANIES:

- All charges are your responsibility on the date that services are rendered. We do not finance accounts. We gladly accept Visa, MC, Amex, Disc, Cash and Check (no post-dated checks will be accepted). Returned checks are subject to additional fees.
- We will provide you with the necessary information for you to file your claim.
- Please check your contract carefully to determine if you are required to see a preferred provider for that company. If you choose to see a non-preferred provider, your insurance may not pay the full amount or will not pay at all.
- Your insurance is a contract between you and your insurance company. Our office is not a party to that contract.

PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED. If the responsible party does not accompany the child to the appointment, payment is still expected on the day services are rendered. Please be sure to send a form of payment with whoever will accompany your child. We WILL NOT bill the responsible party. Accounts with unpaid balances will acquire billing service fees, uncovered by insurance, until balance is paid in full.

DIVORCED OR SEPARATED FAMILIES will be held to the above policy regarding to payments being made at time services rendered. *The parent who accompanies the child to the appointment is responsible for payment*. Please make arrangements for payment with the other responsible party prior. We can provide a treatment estimate to assist you.

24 HOURS NOTICE is requested for all appointments that need to be cancelled or rescheduled. If the appointment is missed, cancelled, or rescheduled with *less than 24 hours' notice your account is subject to a $25 fee per every 30 minutes missed.* Your insurance will not cover any of said charges.

The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the collection agency fees (33.3%), attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state. You agree, in order for us to service your account or to collect monies you may owe, Angelica Rohner, DMD, PA and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

***I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AGREE TO SUPPLY ALL NECESSARY ACCOUNT INFORMATION AND IDENTIFICATION REQUESTED BY ANGELICA R. ROHNER, DMD, P.A.

Responsible Party Signature_____ **Date** _____

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RELEASE OF INFORMATION

Notice of Privacy Practice Acknowledgement

I consent for medical treatment by Angelica Rohner Pediatric Dentistry to apply for insurance benefits on my behalf for covered Services rendered and I authorize the release of medical information for insurance claims, and release of past medical payment history, if needed. I understand that I am responsible for co-pays, deductibles and co-insurance at the time services are rendered. I also, understand I am responsible for any non-covered services. Patients also are responsible for any collection and legal fees in the events of default.

I authorize the release of any medical information necessary to process my insurance claim. I also, certify that the information I have reported with regard to my insurance coverage is correct.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is federal program that requires that all medical records and health information used by us in any form are kept confidential. This Act, gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for misuse of personal health information. If you wish to review a copy of the (HIPAA) Privacy Practice we will be glad to provide you with a copy.

You have the following rights with respect to your dependent's health information.

1. This right to, access, inspect and copy health information.
2. The right to request an amendment to health information.
3. The right to receive an accounting of certain disclosures of health information
4. The right to receive confidential communications.
5. The right to request restrictions on disclosures concerning health information.

****I hereby consent that medical information, treatment and account details can be discussed with the following person or persons. An example would be Spouse, Grand Parents etc. If you want the above information only discussed with you leave the following blank.

Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____

****I hereby consent that appointment reminders can be left on my answering machine, with a family member, or sent by email.

Home Phone: _____ Cell Phone: _____

E-mail (s): _____

Signature of Guardian _____ Date:_____

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