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 Gerwig Family Dental. 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 use for: Social Media and/or Advertising.

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing. Revocation affects disclosure moving forward and is not retroactive.

No Treatment Conditions:
I understand that my treatment will not be altered based on whether or not I sign this authorization.

Patient Name: _____

Date: _____

Signature:_____

If Patient is a Minor

Parent/Legal Guardian:_____

Date: _____

Signature:_____

If desired, copy provided:

o "Yes, I would like a copy of this form." (initialed by team member, copy of this form provided by _____)

Assignment of Benefits

Wayson D. Gerwig, D.D.S.
Chris Gerwig, D.D.S.
4425 98th Street, Suite 100
Lubbock, Texas 79424

I understand that the procedure(s)/service(s) I am receiving may not be paid or covered by my insurance company. I agree to pay for all fees not paid by my insurance company. By signing this form I understand & accept full liability.

Listed below are *some* examples of reasons you will be responsible for the full amount, less any payments previously made. (These are only some of the reasons & not a complete list of denials or rejections.)

- ξ Your insurance has paid its share of the claim
- ξ You have not met your deductible limit
- ξ Non-covered service
- ξ Insurance cancelled
- ξ Insurance has not received information requested from you
- ξ No contract with insurance company
- ξ Claim is over 90 days old with no action from insurance company
- ξ No copy of insurance card in our office

Patient Name (PRINT): _____

Signature of Responsible Party:_____

Date:_____