Todd P. Briscoe, D.D.S., P.C.

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Insurance Release and Financial Policy

Todd P Briscoe, D.D.S., PC is hereby authorized to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations. To the extent allowed by applicable law, rule or regulation, Todd P Briscoe, D.D.S., PC and its employees are hereby released from all legal liability that may arise from the release of information requested to the extent such release was not unlawful.

I further agree and guarantee that in the event the patient account is not paid in accordance with the financial agreement made at discharge, or within (30) days of discharge, to pay for in-office processing fees in addition to the account balance. I further agree to pay all collection costs and reasonable attorney fees to Todd P Briscoe, D.D.S., PC if this account is forwarded to a collection agency or attorney.

I understand and agree that I am financially responsible for all the charges incurred during my treatment.

I further agree as follows:

For patients who have insurance benefits

1. In consideration of my doctor rendering dental services to me or a member of my family for whom I am financially responsible. I hereby assign to Todd P Briscoe, D.D.S., PC all insurance which I have a right to in regard to his bill.

2. In the event the insurance carrier pays benefits directly to me or my spouse (instead of to my doctor as I hereby request) for services performed, I agree that I will immediately deliver all such benefits to Todd P Briscoe, D.D.S., PC up to the amount owed on the patient account, together with collection costs and attorney fees, if any.

For all Patients

I understand that Todd P. Briscoe, DDS, P.C., shall honor any patient's request to not disclose certain protected health information to a commercial health plan if the information solely concerns a health care item or service that I have paid for in full out-of-pocket (i.e. patient pays in full for a service upon delivery of that service and requests that a bill not be submitted to his/her health plan).

RIGHT TO REVOKE: The patient has a right to request a restriction on how their protected health information is used (understanding in some circumstances Dr. Briscoe is not required to agree to the request if not otherwise required by law). Further, I understand that I have the right to revoke the consent given herein with regard to release, use and disclosure of health information at any time by giving Todd P. Briscoe, DDS, P.C. written notice of my revocation. I understand and agree that revocation shall only be effective from and after receipt of such notice and that revocation shall not affect any action taken in reliance on this document and authorization occurring before receipt of such notice. I further understand and agree that Todd P. Briscoe, DDS, P.C. may decline to treat me if I revoke or restrict the authorizations contained herein.

I have been informed that I may review Todd P. Briscoe, DDS., PC's Notice of Privacy Practices before signing this release.

_____ _____

Printed Name of Patient / Guarantor Date

_____ _____

Signature of Patient / Guarantor / Representative Initials of Staff Member

TODD P. Briscoe DDS
CREATING RADIANT, HEALTHY SMILES

PHOTO RELEASE

Photography Consent Form

PATIENT CONSENT - I,

_____

Print Patient Last Name, First Name & Date of Birth

consent to medical images and / or video being made of me, my child, or my dependant. I agree that duplicates may be made for a referring doctor. I understand that Dr. Briscoe will not condition treatment based on receipt of the photo release. I waive the right to inspect or approve the finished photographic product in other provider's releases.

I also agree that the images may be:

(*Please check below to show consent*)

	Yes	No
… placed in my medical record for future treatment	_____	_____
… electronically emailed to my treating health professional	_____	_____
… used by health professionals for education and training	_____	_____
… used in paper or electronic health publications	_____	_____
… used in commercial broadcast	_____	_____
… used in marketing materials	_____	_____
… displayed to, and viewed by, the patients, staff members and other persons who may enter Dr. Briscoe's office	_____	_____

By signing below, I confirm that I understand this consent form.

_____ _____

Signature of Patient/Parent or Guardian: Date

_____ _____

Signature of Doctor/Health Professional/Staff: Date