Appointment Cancellation Policy

Many patients are waiting to schedule an appointment at our office, when someone does not keep an appointment it not only disrupts our schedule but prevents others who may need to come in. Due to this situation we **REQUIRE** 24 hour notice for cancellation. Otherwise a fee of **$50.00** per appointment will be charged to your account.

I have read the cancellation policy and agree: _________

Financial Policy

As courtesy to our patients we will submit claims to your insurance company once. In the event that they do not pay or reject the claim for any reason you will be responsible to pay the total charges. If you do not provide all the information or the correct information needed to submit claim and the office has to resubmit the claim to the insurance company there will be a **$10.00** fee charged to your account.

I have read the cancellation policy and agree : ________

Acknowledgement of Receipt of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to the document our good faith effort to obtain those acknowledgements.

Patient Signature: ____________

Consent for Use and Disclosure of Health Information

Purpose: In cases where Dr. Rastogi has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain patients consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities and healthcare operations, as described more fully in our Notice of Privacy Practices.

Patient Signature: ______________

Consent for Photo Release

I authorize, Dr Rastogi to use my pictures on Family Dentistry of Upper Marlboro's Website or Facebook Page, to include before and after of **TEETH ONLY** . These pictures are for marketing and education purposes.

Patient Name : _____________________ Patient Signature: ________________________________

Date: ____________________________