Majestic Dental
MICHAEL LEAR, DDS

Acknowledgement
Receipt of Privacy Practices
Photo Consent
Financial Responsibility

I acknowledge that I have read and received a copy (upon request) of Majestic Dental Notice of Privacy Practices.

I give Majestic Dental permission to disclose my protected health information to the following individuals involved in my health care and/or payment for health care goods and services

Spouse/Parent _____

Children_____

Other_____

I give Majestic Dental permission to leave detailed messages or text messaging information at the following phone number, regarding my dental treatment or any other healthcare information.

Phone Number_____

I give Majestic Dental permission to contact me at the following email address, regarding my dental treatment or any other healthcare information.

Email address_____

Authorization for Photo Consent

☐ I consent to have photos taken for case presentation, marketing, and misc uses, I understand I will never be identified unless separate permission is given. Photos taken for internal use and/or insurance filing is not included under this consent, and consent for these is included in consent for treatment.

Signature of Patient/Guardian_____

Authorizations: I have read and agree to the terms and conditions and hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to the provider of services. I understand I am financially responsible to Majestic Dental for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to the cost of collection and/or court costs and reasonable fees should this be required.

Printed Name of Patient_____

Signature of Patient/Guardian_____ Date_____

Financial Responsibility Agreement

I (we) assume personal responsibility for and guarantee payment of all sums due and payable to Michael Lear, Jr, DDS, PC (Majestic Dental).

I (we) also assume personal responsibility for and guarantee payment for any minor child that I (we) accompany; regardless of an agreement I (we) may have with any other parent or guardian of the minor child.

I (we) authorize Michael Lear, Jr, DDS, PC (Majestic Dental) and any collection agency and/or attorney which Michael Lear, Jr, DDS, PC (Majestic Dental) may forward my (our) account to for collection, to contact me (us) at any telephone number that I provide or obtained through any public information source or record.

I (we) understand that interest is charged on overdue accounts at any APY of 18% and I (we) will be responsible for all costs of collection including collection and/or attorneys' fees.

I (we) acknowledge that a fee of $50.00 is charged for patients who miss or cancel appointments without more than 48-hour notice. We strive to respect the time committed by our patients and hope that you will respect the time we have allotted for you as well.

Printed Name: _____

Accepted and Agreed: _____ Date: _____

*If you would like a copy of this agreement, we will be happy to make you a copy.