7 CONSENT and RELEASES

- I hereby authorize Dr. Robert Shandrick and/or his team to take photographs, slides, and/or videos of my face, jaws and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care and treatment, and hereby authorize their use for educational purposes in future lectures, professional marketing and demonstrations by Dr. Shandrick and/or his team. I further understand I will receive no further financial compensation for the use, at any time in the future, of my testimonials, photos, slides, or videos by Dr. Shandrick and his team.

- I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to the third party payors, and/or health practitioners.

- I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICE. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS. I understand that my dental insurance is a contract between me and my insurance carrier, and not between the dentist and my insurance carrier. I understand that I will be charged for all dental treatment, and that any payments received by the Dental Office will be credited to my account or refunded to me if I paid the dental fees incurred. I am responsible to pay any co-payments, deductibles, or unpaid balances from my insurance, and that waiving or forgiving copayments and deductibles is unethical and illegal.

- In the event payments are not received by agreed dates, I understand a 1% finance/Accounting fee (12% APR) may be added to my account.

- I hereby authorize doctor or designated staff to take x-rays, study models, and other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of (patient) ___________________________'s dental needs. Upon such diagnosis, I authorize Doctor to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care. I hereby authorize the Dental Office and Doctor, to administer such medicines, and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I understand I can ask for a recital of possible complications.

- I agree that my signature below can be used as a signature on file to process all future insurance claims.

- I have read and understood this entire agreement before signing here below, and I have endorsed this agreement voluntarily, without duress, and of my own free will and choice.

Patient or Responsible Party: **X**____ Date:________________