PERFECT SMILE DENTAL

Payment & Collections:

☐ Patient acknowledges and agrees that all accounts past 30 days shall bear a compounding interest rate of 1.5% per month. In the event that patient does not pay for performed services, Perfect Smile Dental may place patient's account with a collection agency. Patient further agrees to pay reasonable collection fees, attorney fees and court costs incurred in collection of an overdue account.

Photos & Images:

☐ I authorize Perfect Smile Dental to take photographs, x-rays, and/or videos of my face, jaws and teeth as a record of my care.

☐ I authorize Perfect Smile Dental to use photos of a non-clinical nature for their website or social media with the following exceptions:

- ☐ I do not wish to have my First Name shown or released
- ☐ I do not wish to have my entire face shown
- ☐ I only agree to have my teeth shown without any identifying features

☐ I do not expect compensation, financial or otherwise, for the use of these photographs.

Responsible Party:

☐ As the responsible party, in the case where my spouse and/or children are also patients at Perfect Smile Dental, signing this Office Policies form will apply to them and their accounts as well.

_____ _____

Signature of Responsible Party/Cardholder Date

_____

Print Name of Responsible Party/Cardholder

* Subject to credit approval
** Based on plan terms with Care Credit