**Patient Photo Release Form**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Compton Dental Family and Cosmetic Dentistry, or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc.)

I further understand that if the photographs, slides, and videos are used in any publication or as part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I am signing this form for my child/minor whom I am legally responsible for, I also give authorization to Compton Dental to use my child/minor’s photograph, slide, or video in the same situations as stated above. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

**Please initial one option:**

\_\_\_\_\_\_ I do not mind if my photographs are used in any of the above stated situations

\_\_\_\_\_\_ I only agree to have my teeth shown without any identifying features.

\_\_\_\_\_\_ Decline all

Patient Name (print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reschedule Policy**

Thank you for choosing Compton Dental Family and Cosmetic Dentistry. Trying to accommodate every patient’s individual needs and work schedule can be difficult, but we always try to do our best. We work very hard to stay on schedule so that our patient’s wait time is as minimal as possible.

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time just for you. When appointments are missed, canceled, or rescheduled, that time is permanently lost.

We ask when you schedule an appointment that you keep your commitment.

In order to provide the highest quality services to our patients, we have enforced a Reschedule Policy.

Please review the following agreement and sign the appropriate line, indicating that you understand this policy.

*As a patient or guardian for a patient receiving services from Compton Dental Family and Cosmetic Dentistry, I understand the following:*

1. **I am responsible for canceling appointments within 48 hours prior to my scheduled appointment time.**
2. **Should I fail to attend my appointment, reschedule or cancel within a 48-hour period, I will be charged a $50.00 fee.**
3. **Compton Dental Family and Cosmetic Dentistry reserves the right to release any patient due to excessive tardiness, missed or rescheduled appointments.**

 **Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**