CERTIFICATION AND AUTHORIZATION

Patient Name: _____ Date: /___

AUTHORIZATION FOR TREATMENT

I consent to the doctor performing necessary tests, treatments, local anesthetics, and using dental materials for diagnosing and treating oral diseases.

Patient's Signature: _____

CONSENT TO BE PHOTOGRAPHED

I allow the doctor/staff to take and use photos, videos, or audio of me for records, teaching, research, or publication. I will not be identified by name, and any recognizable publication requires my written permission.

Patient's Signature: _____

RELEASE OF INFORMATION

I authorize the doctor to share my treatment information with my insurance company, referring physician, or healthcare facility as needed for care or payment purposes.

Patient's Signature: _____

GUARANTOR AGREEMENT

I agree to pay all treatment charges.

Guarantor's Signature: _____

PATIENT'S ACKNOWLEDGMENT OF PRIVACY PRACTICES

I, _____, may request a copy of the Notice of Privacy Practices from Alex Hoyos DDS, MS, PA.

Opt-Out Preferences:

☐ No appointment reminders on home answering system.

☐ No appointment reminders on business answering system.

☐ No release of health information to: _____.

☐ No phone, email, or text for appointment confirmations.

Print Name: _____

Patient's Signature: _____