Appointment Agreement

I understand that appointments are reserved only for me, and I agree to notify Riggs Family Dentistry promptly if I need to reschedule or cancel. Appointments canceled with less than 48 business hours' notice will incur a $65 charge.

Payment Policy Acknowledgment

- I acknowledge that payment is due in full at the time of service by cash, check, credit card, or debit card.
- For patients with dental insurance, I understand that deductible and non-covered fees must be paid at each visit. Any remaining balance after insurance benefits, if applicable, is my responsibility and must be settled immediately.
- Outstanding balances over 30 days will incur a monthly late fee (greater of $20 or 1% of the account balance).
- I am aware that alternate financing through Care Credit is available.

Photo Release

I authorize Riggs Family Dentistry to disclose all information, x-rays, photographs, or video taken of me or parts of my mouth concerning my dental condition and treatment, including copies of applicable dental and medical records, to:

1.) Any third-party payer covering my services.
2.) Other healthcare professionals and institutions involved in my healthcare.
3.) Disclose as part of any purpose deemed proper by Dr. Riggs in the interest of dental education, knowledge, or research; ensuring my identity is not revealed.
4.) Use for advertising purposes, including social media or print.

By signing below, I acknowledge that I have read, understood, and agreed to the Appointment Agreement, Payment Policy Acknowledgment, and Photo Release.

_____ _____

Patient/Parent or Guardian Signature Date