Assignment of Benefits

Patient Name: (Please Print) _____

I authorize the release of any medical or other information necessary to process this claim.

X_____
Signature Date

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the practice.

X_____
Signature Date

I understand that although eligibility was obtained it is not a guarantee of benefits.

X_____
Signature Date

I understand that I am responsible for any co-payments, deductibles, co-insurance and any procedures not covered by my insurance. I understand that I agreed to my treatment plan and am responsible for any procedures deemed medically unnecessary by my insurance company. **I understand that my co-payment is an estimated calculation and is ultimately determined by my insurance company and that the quote given to me is not a guarantee of my final responsibility.** _____ (initials). Any overpayments will be refunded, and any underpayments will be billed to me after being processed by my insurance company. I understand that the subscriber of my insurance is the responsible party for my account. If my account is sent to a third-party collection agency, I will incur an additional processing fee of $50.00.

X_____
Signature Date

I understand that if payment is sent to me by my insurance company I agree to forward that payment to Dearfield Oral Surgery. Failure to do so will result in full responsibility of balance._____(initials).

X_____
Signature Date

I understand that a balance may be owed depending on how the claim is processed by my insurance.
I hereby authorize payment to my credit card listed below.

Amex ☐ Visa ☐ MC ☐ Debit ☐

Card #_____

Exp. Date_____ CCV#_____

Signature_____