## **ASSIGNMENT OF BENEFITS**

I hereby instruct and direct	
Patient Name	Insurance Company Name
To pay by check made out to	and mailed to
Dentist	Vame Address
	otherwise payable to me under my current insurance policy as
payment toward the total charges for pro-	ssional services rendered. THIS IS A DIRECT ASSIGNMENT
OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my	
Indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner any balance of	
said professional service charges over an	above this insurance payment. A photocopy of this Assignment
Shall be considered as effective and vali	as the original. I also authorize the release of any information
pertinent to my case to any insurance company, adjuster, or attorney involved in this case.	

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of Policyholder

## PATIENT RESPONSIBILITY

Dear Patient,

You will receive services today with the understanding that in the event your coverage is not effective or Benefits are altered you will be billed and held financially responsible for the services rendered.

Patient Name

Subscriber Name

I have Read the above and understand My Possible Financial Responsibility to Smile Maker Dental Center, And Hereby Affix my signature As an Acknowledgement of This Understanding.

Date

I understand that dentistry is not an exact science and that reputable practitioners can not properly guarantee Results. I acknowledge that no guarantee or assurance has been made by anyone regarding the success of Dental treatment, which I have requested and authorized. I understand that no other dentist is responsible for my dental treatment.

I hereby authorize any dentist or dental auxiliaries of Smile Maker Dental Center to proceed with and perform the dental treatments and restorations as explained to me. I understand that this is only an estimate subject to modification due to unforeseen or undiagnosible circumstances that may arise during treatment. I understand that regardless of any dental insurance I may have I am responsible for all payments of dental fees. If the patient or the responsible party defaults in payment, Smile Maker Dental Center may exercise all rights and remedies allowed by law, including the right to hold the patient or the responsible party liable for damages, which are the Unpaid balance, collection fees, and possibly attorney fees.