Assignment of Benefits

I hereby instruct and direct

To pay b

Patient Name *

Insurance Company Name *

Dentist Name

and mailed to

Address *

ZIP / Pc

To pay by check made out to and mailed to For dental expense benefits allowable and otherwise payable to me under my payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND POLICY. This payment will not exceed my Indebtedness to the above mentioned assignee, and I have agreed to pay, in a cu said professional service charges over and above this insurance payment. A photocopy of this Assignment Shall be consid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or case. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Date

Signature of Policyholder

09/14/2023

PATIENT RESPONSIBILITY

Dear Patient,

You will receive services today with the understanding that in the event your coverage is not effective or Benefits are altere financially responsible for the services rendered.

Patient Name *

Subscriber Name

I understand that dentistry is not an exact science and that reputable practitioners can not properly guarantee Results. I ac
guarantee or assurance has been made by anyone regarding the success of Dental treatment, which I have requested and
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 tre
explained to me. I understand that this is only an estimate subject to modification due to unforeseen or undiagnosible circ
during treatment. I understand that regardless of any dental insurance I may have I am responsible for all payments of der
responsible party defaults in payment, Smile Maker Dental Center may exercise all rights and remedies allowed by law, inc
patient or the responsible party liable for damages, which are the Unpaid balance, collection fees, and possibly attorney fe

**I have Read the above and understand My Possible Financial Responsibility to Smile Maker Dental Center, And Hereby A
Acknowledgement of This Understanding.**

Patient/Guardian Signature *

Date

09/14/2023

Send Message

Edit form

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