Insurance Release and Financial Policy

For those patients who have insurance coverage:

1. In consideration of my doctor rendering dental services to me or a member of my family for whom I am financially responsible, I hereby assign to my doctor all insurance which I have a right to in regard to his/her bill.
2. This assignment does not constitute payment for indebtedness and does not relieve the undersigned from liability for unpaid indebtedness.
3. In the event the insurance carrier pays benefits directly to me (instead of to my doctor as I hereby request) for services performed, I agree that I will immediately deliver all such benefits to my doctor up to the amount of my indebtedness to him.

For those patients who do not have insurance coverage:

If I do not have insurance coverage, I understand that I am financially responsible for all bills incurred during my treatment.

Authorization for release of information:

Dr. Samuel L. Corey is hereby authorized to furnish such professional information as may be necessary for the completion of my insurance claim from the medical records compiled during my treatment. Dr. Samuel L. Corey is hereby released from all legal liability that may arise from the release of the information requested.

Unpaid account balances:

I (we) further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made at completion of treatment, or within (30) days of completion of treatment, to pay for in-office processing fees. Past due accounts will be charged 1.5% per month on any unpaid balance. I (we) further agree to pay collection costs and reasonable attorney fees if this account is placed in the hands of a collection agency or attorney.

I have read the above and foregoing and fully understand the terms thereof**.**

_____ _____

Patient's name ***Account ID#***

_____ _____

Patient or Responsible Party Signature ***Date***

_____ _____

Witness ***Date***