INSURANCE ASSIGNMENT AND RELEASE

Dr. Martia L. Leffall
Leffall Family Dentistry
Telephone:
(214)941-5656

I certify that I, and/or my dependent(s), have insurance coverage with _____and

Name of Insurance Company

assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, or Guardian or Personal Representative Relationship to Patient