ASSIGNMENT OF BENEFITS

(7)_____ I hereby instruct and direct **(8)** _____to pay by check
Patient Name **Insurance Company Name**

made out to ART DENTAL CLINIC 5 for the dental expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional 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 and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid 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.

(9) _____ **(10)** _____
Signature of Policyholder **Date**

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.

(11) _____ **(12)** _____
Patient's Name **Subscriber's Name**

I understand that dentistry is not an exact science and that reputable practitioners cannot 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 Art Dental , 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 undiagnosable 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 responsible party defaults in payment, Art Dental may exercise all rights and remedies allowed by law, including the right to hold the patient liable for damages, which are, the unpaid balance, collection fees, and possible attorney fees.
I Have Read The Above And Understand My Possible Financial Responsibility To ART DENTAL**, And Hereby Affix My Signature As An Acknowledgement Of This Understanding.**

(13) _____ **(14)** _____
Patient / Guardian Signature **Date**