Name of Insured Patient :

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ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits be made directly to **Dentistry at 4S Ranch** on my behalf for any services provided to me by that business.

I authorize the release of any medical or other information necessary to determine these benefits,or the benefits payable for related services to the business, Dentistry at 4S Ranch, my Insurance Carrier or other medical entity. A copy of this authorization with be sent to my insurance company, as requested. The original authorization will be kept on file by Dentistry at 4S Ranch.

CHECKS FROM INSURANCE COMPANIES

In certain circumstances, insurance company may send a check for services, provided by Dentistry at 4S Ranch, directly to the patient. In such cases, the patient agrees to endorse and send such checks to Dentistry at 4S Ranch. If the patient deposits such a check into a personal account, the patient agrees to send Dentistry at 4S Ranch a check for the equivalent amount.

Checks can be mailed to the following address: **Dentistry at 4S Ranch, 10432 Reserve Drive, Suite 110, San Diego, CA 92127**

FINANCIAL POLICY

At **Dentistry at 4S Ranch**, we are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, not with your insurance company. Your insurance policy is a contract between you, your employer and the insurance company. Our office is not a party to that contract.

As a courtesy to you, we will help in the processing of your insurance claims. You may direct your benefit payments to be made directly to our office. In order for our office to file your insurance claim, you must bring a completed dental insurance form and proof of insurance coverage at your initial appointment. Payment is due at the time the service is provided. Small, monthly payments and interest-free payment options can be obtained through outside financing (on approved credit).

Balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Returned checks will be subject to a $25.00 fee. If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

I have read and consent to the above policies:

Signed:____________________________________ **Date:** ____________________

Parents Signature_____________________________ **Date:**_____________________

(for minors)