ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with_____
Name of Insurance Company(ies)

And assign directly to Dr._____all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date Signature

MINOR/CHILD CONSENT

I, being the parent or guardian of_____do hereby request
Name of minor/child
And authorize the dental staff to perform necessary dental services for my child, including but not limited To X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I Am present at the actual appointment when the treatment is rendered.

_____ _____
Date Signature of Insured/Guardian

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I agree that spouses are responsible for all fees and services rendered for treatment of a spouse. I accept full financial responsibility for all charges not covered by insurance.

Accounts over 90 days old are automatically transferred to our collection service.

Payment will be made by: Cash____Check____Credit Card_____ECD____CareCredit____

CareCredit is an interest free payment plan. If approved for CareCredit you will pay no finance charges on your balance if you pay at least the minimum monthly payment each month and the entire balance by the due date. If you do not make these payments when due, finance charges will be assessed from the transaction date. The variable APR is 21.98% as of May 16, 2002. There is a $1.00 minimum finance charge.

In event of default on any balance, I/We agree to pay reasonable collection charges and/or attorney fees.

Date_____Signature_____

The information completed on this entire form is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____Signature_____