# Patient Benefits Assignment Statement

I, the undersigned patient (or responsible party), understand and agree to the following regarding the assignment of dental benefits for services provided by this dental office:

- I hereby authorize and request my dental insurance benefits be paid directly to the dental provider for services rendered.
- I understand that my insurance policy is a contract between myself and my insurance company, and that I am ultimately responsible for payment of all services rendered, regardless of insurance coverage or payment.
- I authorize the release of any necessary information to my insurance company to assist in processing my claims.
- I agree to pay any deductible, copays, or charges not covered by my insurance plan in a timely manner.
- I acknowledge that it is my responsibility to inform the dental office of any changes to my insurance coverage or personal information.

By signing below, I acknowledge that I have read, understand, and agree to the above assignment of benefits policy.

_____

Patient/Responsible Party Signature

_____

Printed Name

_____

Date