- **If you do not have dental insurance, payment for services is expected at the time of service.**

  I acknowledge that I understand that payment is expected at time of service unless a payment plan is agreed to and established on my behalf.

  _________ ________________________________

  Date *Patient/Parent/Guardian*

- If you have dental insurance, a portion of your fees will most likely be paid by that plan. Our office staff will gladly assist you in obtaining the benefits to which you are entitled under your plan. Since you are ultimately responsible for all fees assessed, we ask your cooperation in completing and submitting all necessary insurance forms.

- Dental insurance is a contract between you and your insurance carrier, not between the insurance carrier and this office. While we will assist you in receiving the maximum insurance benefit allowable, our office cannot guarantee that your insurance company will pay for treatment you receive from our practice. Should your claim be denied, you will be responsible for payment in full at that time.

- **Insurance payments are usually received within 30-60 days from the time the claim is submitted. Should your insurance company not reimburse our office within 60 days, we ask that you pay the balance at that time and seek reimbursement from your insurance company yourself.**

- While our office will not enter into disputes over claims with insurance companies, we will gladly provide any additional information they may request. The ultimate responsibility for resolution of disputes lies with you, the patient.

- Unless you intend to pay in full for treatment as it is rendered, our office policy requires that the patient assign payment of the allowable insurance payments to our office by signing the agreement below.

I hereby authorize assignment of payment of my dental insurance benefits to _____Dr. James Clayton, DMD, PC_____________________.

This Assignment of Benefits shall be deemed ongoing until my dental insurance carrier receives written notice from me that I have revoked this agreement.

_________ ________________________________

Date *Patient/Parent/Guardian*