

SIGNATURE ON FILE/ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with \_\_\_\_\_  
Name of Insurance Company (ies)

and assign directly to The New Art of Dentistry 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 my 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 \_\_\_\_\_  
Name of minor/child

do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to digital films, and administration of anesthetics if deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

\_\_\_\_\_  
Date Signature

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 accept full financial responsibility for all charges not covered by insurance. I also understand and agree that if I am in default of this agreement, I will pay all reasonable legal fees, court costs, and other costs necessary to collect the debt, including fees charges by a collection agency.

\_\_\_\_\_  
Date Signature