Donald R McGee, DMD, PA
FAMILY & COSMETIC DENTISTRY

ASSIGNMENT OF INSURANCE BENEFITS

IN ORDER FOR US TO PROCESS YOUR INSURANCE CLAIMS, WE WILL NEED YOUR SIGNATURE TO RELEASE PAYMENT.

I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES AND MATERIALS NOT PAID BY DENTAL BENEFIT PLAN, UNLESS THE DENTIST HAS A CONTRACTUAL AGREEMENT WITH THE PLAN PROHIBITING ALL OR A PORTION OF SUCH CHARGES. TO THE EXTENT PERMITTED UNDER APPLICABLE LAW, I AUTHORIZE RELEASE OF ANY INFORMATION RELATION TO ANY CLAIM FOR SERVICES RENDERED TO ME OR TO MY DEPENDANTS.

I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO DR. DONALD R. MCGEE, DMD PA.

_____
PATIENT'S NAME (PLEASE PRINT)

_____ _____
AUTHORIZING SIGNATURE (PARENT/GUARDIAN IF PATIENT IS UNDER 18 YRS) DATE

_____
RELATIONSHIP OF PATIENT & AUTHORIZING SIGNER