ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company or any other insurance company to pay proceeds of any benefits for dental services rendered to me by Hudson Dental directly to Hudson Dental. I understand that payment will be made to Hudson Dental and not to me. If I receive payment from my insurance company, I agree to surrender payment immediately to Hudson Dental.

Date: _____ Signature: _____

RECORDS RELEASE

I hereby authorize the release of any information obtained by Hudson Dental regarding my treatment to my insurance company in order for them to process my insurance claims. Information released may include examination results, x-rays, health history and treatment notes.

Date: _____ Signature: _____

PAYMENT OF ACCOUNT

I acknowledge and understand that I am responsible for ALL charges for dental services rendered to me by Hudson Dental. I am responsible for my deductible and co-pay, if required, *on the date services are provided.* Any charges that my insurance company denies or refuses to pay, I agree to pay *IN FULL* within 30 days of the billing date. Bills past due will be turned over to a collection agency, and I understand that I will be responsible for any fees incurred as a result of the collection process. *If I fail to notify Hudson Dental 24 hours before canceling a scheduled appointment, I may be liable for an office call charge.*

Date: _____ Signature: _____

CONSENT FOR MINORS

Parental or Guardian Consent is required for anyone under the age of 18. I hereby authorize Hudson Dental to provide examination, x-rays and/or treatment for: _____

Date: _____ Signature: _____

DR. TOM KLOSTER
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