ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this as though the undersigned had personally signed the particular claim.

I_____ hereby authorize _____
(Name of Insured) **(Name of Insurance Company)**

to pay and hereby assign directly to Drs. Halpern & Halpern, P.A. all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Drs. Halpern & Halpern, P.A. will be credited to my account, in accordance with the above said statement.

_____ _____
(Authorized Signature if Subscriber) **(Date)**

FINANCIAL CONSENT

1. I understand that no guarantee can be made for complete insurance coverage for any service.
2. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service, regardless of insurance coverage.
3. I understand that outstanding balances 90 days and older will accrue a monthly finance charge of 1.5% (18% yearly), and such delinquent account balances may be turned over for professional collections.

_____ _____
(Signature of Responsible Party) **(Date)**

TREATMENT CONSENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
(Name of Patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____