## Assignment of Benefits

I hereby authorize Cordata Family Dentist to bill my insurance carrier or any other payment source. I assign all benefits and authorize payment directly to Cordata Family Dentist for any benefits otherwise payable to me for all claims for such services provided or submitted prior to, or after, the date provided on this form. I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. This assignment and authorization in no way releases me from said responsibility and imposes no obligation on Cordata Family Dentist to collect money on my behalf. I have read, understand and agree to all the information on the financial policy. A photocopy of this agreement may be used as though it were an original. This Assignment of Benefits will be effective until revoked by me in writing. Such revocation shall have a prospective effect only.

Patient Name: ________________________________________

Patient/Guardian Signature: ________________________________________

Date: ________________________________________