

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with \_\_\_\_\_ and assign directly to Dr. Naeem, D.D.S. 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 insurance. I hereby authorize the doctor to release all information necessary to secure 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 \_\_\_\_\_, do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I'm 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 arrangement are made. I agree that parents/ guardians are responsible for all fees and services rendered for treatment of a child/ minor. I accept full financial responsibility for all charges not covered by insurance and also acknowledge that there will be a \$45.00 charge on my account that is sent to outside collections.

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