Authorization and Responsibility Agreement

We invite you to discuss with us any questions regarding our services or policies. The best health services are based on friendly, mutual understanding between provider and patient.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.

I hereby authorize my insurance company to pay directly to Jeffrey H. Forrest DDS P.C. any professional or dental expense benefits for services rendered. If my insurance company does not pay my balance in full within 30 days, I will be responsible for contacting my carrier to inquire about the delay.

I authorize Jeffrey H. Forrest DDS P.C. to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release Jeffrey H. Forrest DDS P.C. from any consequence thereof. A photocopy of this assignment shall be considered as affective and valid as the original.

I understand it is my responsibility to inform this office of any changes in my dental insurance status.

_____   _____
Signature of patient or responsible person   *Date*

Financial Responsibility

Our Office policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager, or current and complete insurance information is submitted. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 60 days past due, a service fee will be added to the balance owed. If any account is turned over to our collection agency a 50% fee will be added to the account to cover the agency fees.

Returned checks will be accessed a $15 fee each time it is declined by the bank. We will put an NSF check through twice. (If payment on a collection account is returned it will be accessed a 50% fee).

_____   _____
Signature of patient or responsible person   *Date*