Emily S. Gausman, DMD
405 North Main Street
Jamestown, New York 14701

Patient_____

ASSIGNMENT AND RELEASE (INSURANCE)

I, the undersigned, have insurance with _____ (Insurance Company Name) and assign directly to Dr. Emily S. Gausman 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 the 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 _____(Name of minor/child) 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 am present at the actual appointment when the treatment is rendered. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____

Date Signature of Insured/Guardian

FINANCIAL AGREEMENT

I understand that accounts are due **on the day** of service. Balances over 90 days are subject to a late payment charge of $10.00 per month. If the account is sent to collections I accept full financial responsibility for all fees from the collection agency.

_____ _____

Date Signature