ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits to **NEW HORIZONS DENTAL CARE of LENEXA** for the services described.

I give my permission to the doctor to submit insurance benefit claim forms in my name and on the behalf of myself, my spouse and / or my minor children.

I realize that I am responsible for and agree to pay any charges not covered by my insurance. This includes unmet deductibles, non-covered services, etc.

CO-PAYS AND CASH PLANS ARE DUE AT THE TIME OF SERVICE.

If I allow my account to become delinquent and it is referred to a collection agency, I am **SOLEY** responsible for any outstanding balances and **ALL** reasonable collection costs and attorneys fees.

Special arrangements can be made, but must be mutually agreed to **IN ADVANCE**. Please contact the staff at any time if you have any difficulties. We will do everything possible to find a way to provide the dental care services you need.

A fee of **$50** will be charged to you for cancellation without 24-hour notification or failure to show for dental hygiene appointments.

A fee of **$75** per hour scheduled will be charged to you for cancellation without 24-hour notification or failure to show for dental treatment appointments.

Date: ______________________________

Patient's signature: ____

Office representative: ____