**James M. Seaver, D.D.S.**
**Tyler L. Pittman, D.D.S., P.C.**
**Michael Cagle, D.D.S**

# *Assignment of Benefits Agreement*

Our office is pleased to accept your insurance assignment. We offer this service as a courtesy to our patients. However, it must be clearly understood that the **"contract" is between the patient and the insurance company**, the account thereby being the **responsibility of the patient** for any amount not paid by the insurance company. Following is a statement of our policy governing insurance claims. The **patient will pay the co-payment** (the amount **estimated** as not covered by the insurance company) at the time services are rendered. After we receive payment from your insurance company, **any difference will be billed to you**. We expect payment within 10 days after receipt of your statement.

**WE ONLY ESTIMATE WHAT YOUR INSURANCE WILL PAY!!!**

IF YOU UNDERSTAND AND AGREE TO THE ABOVE OFFICE POLICIES PLEASE SIGN YOUR NAME BELOW AND WE WILL ACCEPT YOUR INSURANCE ASSIGNMENT.

## PAYMENT OPTIONS

To reduce our administrative costs and keep our fees to you as low as possible, we ask that you pay your co-payment at the time you receive treatment.

Please indicate below the method of payment you intend to use to pay for your dental treatment, including your co-payment.

**PAYMENT OPTIONS:**

_____ Cash or Check

_____ Visa / Master Card /Amex / Discover

**EXTENDED PAYMENT OPTIONS:**

_____ Our Financial Lending Institution
(Balances over $300.00, please inquire with our financial coordinator).

**Please sign below letting us know that you have read and agree to the above office polices.**

_____ _____
**Patient or Guardian Signature** **Date**