Assignment of Dental Benefits

I hereby authorize payment directly to Patrick S. Burchfield, D.D.S., P.C. otherwise payable to me for services rendered.
I authorize this provider or any of his representatives to release information concerning my findings, diagnosis or treatment to the insurance company or a third party company if I failed to pay my bill. I also authorize the insurance company to release any information concerning the status of my dental claims and payment information to this provider and his representatives.

I understand that it is also my responsibility to make sure that my physician is in-network with my insurance company, and if I need to notify my provider for any previous treatment I have had, any exclusions under my plan, waiting periods, or frequencies under my insurance policy.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

______________________________ __________
Patient/Guarantor Signature Date

Rev 10/12/11 crb