ASSIGNMENT AND RELEASE

I assign directly to Dr. Daniel J. Ryan all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release any information pertinent to my case to any insurance company or adjuster. I authorize the use of the signature below on all insurance submissions.

Our office will verify eligibility of your insurance benefits. We will also facilitate billing your insurance company **Verifying eligibility is not a guarantee of payment.** Most insurance plans are designed to cover only a portion of the total cost and many contracts have limitations. **I understand that I am financially responsible for all charges, whether or not paid by my insurance company.**

FINANCE AGREEMENT-AUTHORIZATION FOR TREATMENT- RELEASE OF RECORDS-INFORMED CONSENT-
I hereby authorize and request Dr. Daniel J. Ryan to disclose and give copies to another dental office, any and all records concerning the undersigned, which you have in your possession, per my request.

I agree to let Dr. Daniel J. Ryan do an oral examination inside my mouth, and listen to his recommendations. I understand that if I do not follow through with his treatment recommendations that the results could be less than optimum. If any unforeseen condition should arise in the course of treatment, calling for Dr. Ryan to judge that procedures are needed in addition to, or different from those contemplated, I request & authorize Dr. Ryan to do whatever he may deem advisable. Due to individual patient differences, there exists a risk of treatment failure or worsening of my present condition despite the care provided. No guarantee of assurance has been given to me regarding the result and/or cure of my condition.

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentation thereof; unless financial arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determine proper.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof (a copy of this assignment as valid as the original). A FINANCE CHARGE OF 1.5% per month (or a minimum of $2.00 for balances under $134, which is an ANNUAL PERCENTAGE RATE of 18% will be charged on all account balances 60 days & over).

AGREEMENT: The above information is for the purpose of verifying insurance eligibility and employment verification. This information may be used to obtain credit and is warranted to be true.

APPOINTMENT: When an appointment is made, we reserve that time exclusively for you. A charge of $60 may be levied for each appointment missed or canceled without 48 hour notice. NOTICE: Please read before agreeing to the conditions set forth. You are entitled to a copy of this agreement at the time you sign. RESPONSIBLE PARTY

RESPONSIBLE PARTY SIGNATURE____

DATE__________________