Favour Dental

Dr. Troy Bonin

5403 FM 1488 Suite A7
Magnolia, Texas 77354
281.259.6717

ASSIGNMENT OF BENEFITS

I herby instruct my insurance carrier and direct Dr. Troy Bonin and/or associates to pay allowable benefits directly to the office of Dr. Troy Bonin and/or associates.

All payments will be made to Smiles LLC/Favour Dental of address, 5403 FM 1488 Suite A7 Magnolia, Texas 77354. The payment rendered in my behalf will be otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I understand if payment made directly to me, could then result in unpaid balance with the office. Favour Dental advises calling the office to confirm payments prior to depositing.

Initials THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY

This payment will not exceed my indebtedness to the above-mentioned assignee and I have agree to pay in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of the assignment shall be considered as effective and valid as the original. I also authorize the release of my information pertinent to my case to any insurance company, adjuster, or attorney involved.

Initials I authorize Favour Dental to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

PATIENT RESPONSIBILITY

Initials You will receive services today with the understanding that in the event your coverage is not effective or benefits are altered, you will be billed and held financially responsible for the service rendered.

I understand that dentistry is not an exact science and that reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the success of dental treatment, which I have requested and authorized. I understand that no other dentist is responsible for my dental treatment. I hereby authorize any dentist or dental auxiliaries of Favour Dental, to proceed with and perform the dental treatments and restorations as explained to me. I understand that this is only an estimate subject to modification due to unforeseen or un-diagnosable circumstances that may arise during treatment. I understand that regardless of any dental insurance I may have, I am responsible for all payments of dental fees. I, the patient or responsible party, defaults in payment, Favour Dental, may exercise all rights and remedies allowed by law, including the right to hold the patient liable for damages, which are, the unpaid balance, collection fees, and possible attorney fees.

I have read the above and understand my possible financial responsibilities to Favour Dental and hereby affix my signature as an acknowledge of the understanding.

Patient Printed Name:_____ Date:_____

Signature (Patient or Legal Guardian):_____