Pine Mountain Dental Care of Kennesaw

ASSIGNMENT OF BENEFITS

I, ___________________________________ hereby authorize payment directly to

Pine Mountain Dental Care of Kennesaw, Dr. Thomas H. Turner, D.D.S.

for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered in my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I also authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _______________________________ Date:__________

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