SEVEN HILLS ORTHODONTICS
CARLOS BORDADOR, DMD, MS • SEAN TRUONG, DDS

INSURANCE ASSIGNMENT AND RELEASE

Patient Name: _____

I certify that I and/or my dependent(s), have insurance coverage with _____ and assign directly all insurance benefits directly to Seven Hills Orthodontics, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Responsible Party Date

_____ _____

Please print name of Responsible Party Relationship to Patient