ASSIGNMENT OF BENEFITS AND PAYMENT AGREEMENT

I hereby authorize and notify by this written agreement, signed and dated below, that my insurance carrier assign all proceeds and benefits to which I may be entitled to under their policy issued to me or that I hold certificate to said policy, be assigned to **JANET D. TRAN, DDS, PA, /CARE MOST DENTAL**, for any dental treatment rendered to me, subject only to the exclusions and deductibles of the insurance policy. **SHOULD A BALANCE EXIST IN THE TOTAL BILL AFTER THE INSURANCE CARRIER HAS FUFILLED ITS OBLIGATION UNDER THE POLICY, I REALIZE THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF THE REMAINING BALANCES**. If the insurance carrier of patient fails to make payments for care and services rendered, it is understood that such steps as are authorized by law will be taken for the enforcement of the rights under the Assignment and Agreement.

Note: Our office will reach you directly or by message prior to your appointment to remind and confirm your appointment time. **There will be a $30.00 CHARGE for all NO SHOWS and SAME DAY cancellations.**

I have read, understand, and agreed to the above terms and conditions.

_____

Signature (If minor then parent signature) Date