ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/OR MY DEPENDANTS, HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO Little Heroes Pediatric Dentistry ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSILE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

DR AZI ARDAKANI MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE NAMED INSURANCE AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR BENEFITS PAYBLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

ACKNOWLEDGEMENT: RECEIPT OF DENTAL MATERIALS FACT SHEET

_____ I ACKNOWLEDGE I HAVE RECEIVED A COPY OF DENTAL MATERIALS FACT SHEET.

ACKNOWLEDGMENT: RECIPT OF NOTICE OF PRIVACY PRACTICES

_____ I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THIS OFFICES NOTICE OF PRIVACY PRACTICES.

PRINT NAME _____

SIGNATURE _____

DATE _____

RELATIONSHIP TO PATIENT _____