VALERIN DENTAL
6901 N. Knoxville Ave. #202 · Peoria, IL 61614 · 309-693-2310

ASSIGNMENT OF BENEFITS AND RELEASE

I, the undersigned, understand that I am financially responsible for all charges whether or not paid by insurance for services rendered by this office. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature Date

_____

Printed Name

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FINANCIAL POLICY

Financial Guarantee, I _____(patient or guarantor) agree that in consideration of services rendered by Dr. Valerin and/or Valerin Dental at 6901 N Knoxville Ave Suite 202 Peoria, IL , I will be personally responsible for any and all the expenses incurred for such treatment. Also, I agree that if I fail to make payment in full or if I fail to make an agreed upon payment arrangement and my account becomes past due, I shall be liable for and I agree to pay all collection agency fees and/or attorney's fees and court costs. I understand that this office will make a reasonable effort to collect from my insurance company but ultimately the responsibility for charges is mine.

_____ _____

Responsible Party Signature Date

_____

Printed Name