**Simple Agreement Form**

Patient authorizes the Doctor to deposit checks received on Patient’s account when made out to the Patient.

**Signature**:

**Date**:

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

PATIENT NAME:

EMPLOYER:

GROUP #:

SS # / ID #:

I hereby instruct and direct the Insurance Company to pay by check made out to and mailed directly to:

Healthy Smiles Dental

3000 Annandale Rd. #106

Falls Church, VA 22042

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o Healthy Smiles Dental

3000 Annandale Rd. #106

Falls Church, VA 22042

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

*A photocopy of this assignment shall be considered as effective and valid as the original.*

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

I also authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at Fairfax County, this of ,

Day Month Year

Signature of Policyholder Witness

Signature of Claimant, if other than Policyholder