ANDREW L. BOGDANOWICZ D.D.S., P.C.

7048 W. Higgins Ave.
Chicago, IL. 60656
Tel.: (773)775-7090 Fax: (773)775-2858

ASSIGNMENT OF BENEFITS/GUARANTEE OF PAYMENT:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable directly to me. I authorize release of my records to third party payers, other healthcare professionals or operations or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines necessary. I understand re-billing fee of $20 will be imposed each month on account that is over thirty (30) days past-due.

APPOINTMENT POLICY:

Your appointment time is reserved exclusively for you. If for any reason you are unable to keep your appointment, notice must be given prior to the appointment time or a fee may be applied.

CONSENT FOR TREATMENT:

I authorize the dentist and supervised assistants to administer treatment and medications as deemed necessary or advised by the dentist.

I acknowledge receipt of this office's Notice of Privacy Practices.

I have reviewed the information on this form, and it is accurate to the best of my knowledge.

Patient's Name:_____

Responsible Party (if not patient):_____

Signature:_____ Date:_____