ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance or Medicaid coverage with ______________________________ and assign directly to Dr. William Hartman & Assoc. Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance or whether or not I have insurance.** I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. **We will collect your estimated portion on the day that you have any work done. If after your insurance pays and if there is still a remaining balance due we will send you a bill for the remaining balance.**

____
Responsible Party Signature

____
Relationship

____
Date