

JACQUELINE JOHNSON-CURL, DDS  
FAMILY DENTISTRY  
5007 BROOK ROAD, RICHMOND, VA 23227

ASSIGNMENT AND RELEASE:

I, the undersigned, have insurance with \_\_\_\_\_ and assign directly to Dr. Johnson-Curl all 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. I hereby authorize the use of this signature on all my submissions whether manual or electronic.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

MINOR/CHID CONSENT:

I, being the parent or guardian of \_\_\_\_\_ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the dentist, whether or not I am present at the actual appointment when treatment is rendered.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

FINANCIAL AGREEMENT:

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered of a minor/child. I accept full financial responsibility for all charges not covered by insurance. I also understand that I will be held responsible for all charges incurred on my account. It is further agreed that if I do not pay within 30 days, I will pay finance charges of 2% per month on the unpaid balance until paid. If it becomes necessary to proceed with collection action because of non-payment, it is further agreed that I will pay collection expenses court costs and or attorney's fees of 25%.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_