Dr. James J. Lynn Family Dental Health Care
105 Sheringham Drive
Easley SC 29642
864-269-0600

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize and direct payment of my dental benefits to Dr. James J. Lynn D.M.D., P.A. for any services furnished to my dependents or myself. I authorize the facility to release any information, including diagnosis and the records of any treatment or examination rendered to my family members or myself during the period of such dental services, to third party payers and/or health practitioners. In the event that my dental plan determines a service to be "not covered", I understand that I will be responsible for the complete charge. **I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed.**

_____ _____
Sign and Print Name of Patient (or Responsible Party) Date

PAYMENT

I hereby assume responsibility to pay the costs of all services provided by Dr. James J. Lynn D.M.D, P.A. I understand that Dr. James J. Lynn D.M.D, P.A., files claims at no charge as a courtesy to patients. Furthermore, due to the multitude of different insurance plans and policies, it is my responsibility, as the patient, to determine my particular plan coverage. I acknowledge that Dr. James J. Lynn D.M.D., P.A. does not have access to my benefit requirements and is not responsible for non-payment of insurance benefits on my dental procedures. **My portion of what insurance does not cover, plus my deductible, is due on the day of my appointment.**

_____ _____ _____
Sign and Print Name of Patient (or Responsible Party) Date

AUTHORIZATION OF PAYMENTS

I understand that Dr. James J. Lynn D.M.D., P.A. will assist me in submitting my claim to my insurance carrier. I hereby authorize payment of dental benefits directly to Dr. James J. Lynn D.M.D., P.A., otherwise payable to me, for the services provided. **I understand that I am financially responsible for my dental insurance deductibles, coinsurance, and non-covered services on the day services are rendered**.

_____ _____ _____
Sign and Print Name of Patient (or Responsible Party) Date