AUTHORIZATION AND ASSIGNMENT: Please read and sign the following statement.

I directly assign all dental benefits to Dr. Fairclough and Mayer, D.M.D., P.C. and understand that I am financially responsible for all charges not covered by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

It is customary that payment be made when services are rendered unless arrangements have been made in advance. In the event of non-payment, either by insurance or myself, I agree to pay all costs of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract.

Your appointment time is scheduled for you alone and usually cannot be filled if you cancel on short notice or fail to come. If you must cancel or reschedule, please be courteous and give us as much advance notice as you can.

Date:________________ Signature:____