

William L. Eick, D.D.S.
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PATIENT AGREEMENT FORM

I, the undersigned, certify that I (or my dependent) have dental insurance coverage with _____ and assign directly to William L. Eick, D.D.S. 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. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. Also, I understand that any unpaid insurance claim that has aged 30 days will be turned over to the patient's account and I will be responsible. After 90 days the balance will be sent to a collection agency and a processing fee will be added onto the balance. I authorize the use of this Signature on all insurance submissions.

Responsible party signature

Date

Relationship to patient