

Telephone:  
440-333-1915



**WILLIAM L. EICK, D.D.S.**  
PROFESSIONAL ARTS BUILDING  
21851 CENTER RIDGE ROAD  
ROCKY RIVER, OHIO 44116

### Patient Agreement Form

I, the undersigned certify that I (or my dependent) have dental insurance coverage with \_\_\_\_\_ and assign directly to Willilam 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 patients 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