Insurance Assignment Release

I understand and agree that I am responsible for my account. I also understand that after my insurance company pays its portion, there could be a balance remaining. As a service to you, we will submit your claim a second time if necessary. If payment is still not received, you will become fully responsible for the unpaid claim.

I hereby authorize the office of Ronald J. Tosch, DDS to place my name on all claims and documents that are related to my insurance.

I hereby grant permission for my insurance company to pay by check payable and mailed to Dr. Tosch. If my current policy prohibits direct payment to Dr. Tosch, I hereby instruct my insurance company to make the check out to me, and mail it in care of Dr. Tosch.

I Authorize the release of any information to my insurance company relating to my dental claims.

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Patient Name

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Signature of Insured **Date**