Paul L. Saunders

Short Pump Crossings

3422 Pump Road

Richmond, VA 23233

AUTHORIZATION FOR SUBMISSION

OF CLAIMS AND

ASSIGNMENTS OF BENEFITS

I authorize the health care provider named above to submit claims for payment for services to the health care service plans or insurance companies named below on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

1. _____

Primary Insurance

2. _____

Secondary Insurance

_____ _____

Date Name of Dentist

_____

Signature of Patient, Parent or Guardian

AGREEMENT TO PAY

I understand that payment for services rendered are due upon performance of these services. I understand that in the event that my account is turned over to an attorney for collection, I will be responsible for all cost of collection, including attorney's fees.

_____ _____

Print Name Date Signature of Patient, Parent or Guardian