

Northern Arizona Endodontics
1000 Willow Creek Road Suite K
Prescott, Arizona 86301
(928) 778-7181

Date: _____ Name: _____

Assignment and release: I certify that I (or my dependents) have insurance coverage with_____. I assign directly to Dr. Rodney Brimhall all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for the total treatment fee whether or not paid by my insurance. I understand Northern Arizona Endodontics can not guarantee benefits and insurance benefits quoted are an estimate only. Also, the amount quoted as patient portion is an estimate as well. We allow 30 days for your insurance company to make a payment. After this time, the total balance *could* be due and payable in full. Your prompt response to your insurance company's or our requests for information is expected. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signed: _____ Date: _____

Treatment fee for this root canal: _____

Estimated insurance benefits applicable for these appointments: _____

Estimated patient portion: _____

Patient portion: Cash _____ Check _____ Credit Card _____
(Check One)

Financing Care Credit Estimate Monthly Payment: _____

Payment is expected at the 1st appointment.

Signed: _____

Date: _____