# O’Leary Dental Office
## Dr. Kevin S. O’Leary

Patient______________________________________________________

Address_____________________________________________________

Insurance
Carrier______________________________________________________

**Assignment of Payment**

My insurance carrier is  here by requested and authorized to pay directly to **O’Leary Dental Office** for any service rendered.

Further, I agree to pay **O’Leary Dental Office** the difference, if any, of the agreement between the insurance carrier and O’leary Dental Office.  It is my responsibility to pay any deductible and/or coinsurance that are remaining after my insurance company has issued payment and/or denial.

It is further understood that I, the undersigned agree to pay **O’Leary Dental Office** the full amount of charges should my treatment be such that is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

**O’Leary Dental Office** will file the billing information in a timely manner, unless otherwise instructed by the patient or primary insured.

Furthermore, I agree that if for any reason I cancel my appointment with **O’Leary Dental Office** in less than 24 hours of appointment (48 hours for a Monday appointment); I will be charged a fee of $30.00.

By signing below, I agree that I have read this financial agreement between myself (the patient) and **O’Leary Dental Office** and understand the financial agreement.

Date________________________

Signed________________________________

Witness_______________________________