Reza Azari, D.D.S.

INSURANCE ASSIGNMENT AND RELEASE

I, hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Reza Azari, I also authorize the release of any information pertaining to my dental claim. **The patient will be responsible for any co-payments, deductibles, non-covered services and any portion that is over benefit year maximum.**

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I agree that I am responsible for all fees and services rendered for treatment and accept full financial responsibility for all charges not covered by insurance.

APPOINTMENT POLICY

1. 24 hour notice is required for the cancellation of dental appointments. Less than 24 hour notice is considered a missed appointment.

2. Periodic examination and cleaning is recommended every 6 months for our active patients. Failure to do so, will result in you becoming a inactive patient. This will be a consideration for withdrawal from our services

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS:

_____ SIGNATURE

_____ DATE