TO OUR PATIENTS

- I authorize Dr. Daniel Mashni to perform dental procedures on myself as needed, to take dental xrays to diagnose conditions that are needed for treatment.

- I understand that I am responsible for payment of services rendered and also responsible for paying and co-payment and deductible that my insurance does not cover

- I understand that payment is due at time that services are rendered

- I authorize my insurance company to pay by check made out to Daniel D Mashni DDS, PLLC. This is a direct assignment of my rights and benefits under this policy

- I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case

- I understand that I am subject to a $35 dollar cancellation fee if no notice is given within 24 hour period.

SIGNATURE: _____

DATE: _____