Oxford Smile Center

John M. Khoury, Jr., D.D.S.
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ASSIGNMENT OF BENEFITS

The undersigned patient of Dr. John Khoury, for and in consideration of the services to be rendered by said doctor for me or at my request, does herby ASSIGN, all of my right, title and interest in and to any payment of recovery which I may receive from my own first party insurance or from any third party, which may be related to or arising out of these services. I hereby direct my own first party insurance carrier or any third party who may be obligated to make payment for these services, to make that payment directly to John Khoury, D.D.S. **I ACCEPT FULL RESPONSIBILITY FOR BALANCES NOT COVERED BY MY INSURANCE.**

SIGNED____DATE_______________

YOUR COPAYMENT FOR TREATMENT IS BASED ON AN **ESTIMATE ONLY**, GIVEN TO US BY YOUR INSURANCE COMPANY. WE CANNOT GUARANTEE, IN ANY WAY, THAT YOUR INSURANCE WILL COVER THE COST OF SERVICES RENDERED BY DR. KHOURY.