Mann Family Dental, LLC
Insurance Assignment of Benefits and Release

I the undersigned, certify that I have insurance coverage with _____ and assign directly to **Dr. Tyler Mann, DDS** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by insurance and that all amounts deemed my responsibility for co-pays, co-insurance, deductibles and or non-covered services will be paid in full on the date of service unless otherwise agreed upon in advance by **Dr. Tyler Mann, DDS** or his authorized representative. I hereby authorize **Dr. Tyler Mann, DDS** access to any and all information necessary to secure payments on my behalf for services rendered under his care. I authorize the use of my signature on all insurance submissions whether paper and/or electronic.

I understand that it is my responsibility to contact my insurance company or my Employee Benefits Coordinator where I work regarding coverage, benefits, deductibles, and/or pre-certification requirements.

Patient Signature: _____

Witness: _____

Date: _____