Patient Agreement

I hereby assign all dental benefits, to include all private insurance and other health plans with dental coverage, to Dr. Michael R. Errico and Associates.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of my dental/medical records and release of information necessary to secure payment from said insurance company.

In the event that I personally receive payment by my insurance company, whether it be by check or deposit for the services to be rendered to me by Dr. Michael R. Errico and Associates, I hereby agree to forthwith and instanter deliver said check to Dr. Michael R. Errico and Associates, with my endorsement for deposit and payment for services rendered to me by Dr. Michael R. Errico and Associates.

If there is a balance due on my account after receipt of insurance payment, I agree to pay the full amount of the check within ten(10) days of receipt of the check.

I understand that my dental insurance is based upon a contract between myself and/or my employer and the insurance company. I understand that Dr. Michael R. Errico and Associates practice is in no way associated with the contract between myself and my insurance company. Therefore, I understand that I am responsible for the terms of benefits of my insurance.

I understand that submitting claims to the insurance company is a courtesy that is being provided to me by Dr. Michael R. Errico and Associates.

I understand that should I fail to comply with set agreement and/or fail to pay any balance owed to Dr. Michael R. Errico and Associates that I am subject to filing of a civil lawsuit to collect the fees for services rendered to me by Dr. Michael R. Errico and Associates and that I will be liable for any and all reasonable Attorney fees in connection with the collection efforts and any and all court costs incurred by Dr. Michael R. Errico and Associates.

I also understand that in the event I deposit or cash any insurance check that I may be subject to the criminal charges for theft of services.

Any and all complaints will be filed in the Circuit Court of Cook County, State of IL

I understand the contents of this Patient Agreement and I agree to honor them.

_____ _____

(Patient Name) **(Date)**