## ASSIGNMENT OF BENEFITS

As a service to our patients, we accept the assignment of your insurance benefits directly to our office, upon verification of coverage.  Estimates of coverage are not a guarantee of benefit.

I authorize the office of Dr. Brenda Fritz to use my signature on my insurance submissions and allow the release of information necessary to secure payment of benefits.  I understand that I am responsible for any amounts not paid by my insurance company within sixty days.

**Patient Signature:** ______________________________________________

## AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

I agree that the office of Dr. Brenda Fritz may communicate with me electronically at the email address below.  I am aware that there is some level of risk that third parties might be able to read unencrypted emails.  I am responsible for providing the dental practice any updates to my email address.  I can withdraw my consent to electronic communications by calling the office of Dr. Brenda Fritz (706-692-6429).

**Patient Signature:** ______________________________________________

## PHOTOGRAPHY RELEASE

I AUTHORIZE THE OFFICE OF Dr. Brenda Fritz to take photographs of my face, jaws, and teeth.  I understand that any of these may be used in educational purposes or as part of a demonstration.  My name or any identifying information will remain confidential.  I do not expect compensation in any form for the use of these photographs.

**Patient Signature:** ______________________________________________