ASSIGNMENT OF DENTAL BENEFITS AUTHORIZATION FORM

I,______________________________________authorize Signal Hill Dental Centre/Greg Longay Prof Corp, to apply any outstanding balance on my account not covered by my insurance company or companies to the credit card listed below. I understand that the amount I pay directly at the time of my appointment is generally an estimated amount based on the limited details Signal Hill Dental Centre has of my dental plan and coverage.

Please list any dependents and spouse that will be using the Credit Card for direct billing to your dental insurance:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

I understand that Signal Hill Dental Centre will send a copy of the credit card receipt as well as any "Explanation of Benefits" from my insurance company to my current address.

Name on credit Card:_______________________________________

Credit Card #:____

Expiration Date:___________________________

Signature of Card Holder: ___________________________________

Today's Date: _____________________________