Mary Paige Huxford, DMD, PLLC
Tammi Lockhart, DMD
100 Brandon Road, Suite W
Starkville, MS 39759

Patient Name: _____

Responsible Party Name: _____

ASSIGNMENT OF BENEFITS
RELEASE OF INFORMATION

I authorize **Mary Paige Huxford, DMD, PLLC/Tammi Lockhart, DMD** to release all information necessary to secure the payment of benefits. I authorize any payment of any insurance claim directly to Mary Paige Huxford, DMD/Tammi Lockhart, DMD. I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that I am responsible for all services, due and payable by the dates agreed upon. I understand that if my account becomes delinquent, I will be responsible for any additional charges incurred in the collection of my account.

Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses, including the collection agency's fee, court cost, and all expenses related to the cost of collecting the account.

In addition, this agreement shall be governed by, and construed in accordance with the laws of the state where the assigned collection agency and/ or attorney is located, exclusive of choice of law rules. The parties each hereby consent to the jurisdiction and venue and waive any objections to such jurisdiction and venue.

Signature _____

Date_____