

# Dental Service – Assignment Form

Please photocopy and complete this form for assigning dental service collection accounts.



Principle Amount	Patient's Full Name	Responsible Party if different from Patient			
Interest Rate	Last known address	City	Prov	Postal	
Last Treatment Date	Spouse Name	Last known employer & location			
SIN	Date of Birth	Phone Number	NSF Cheque <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	Acct Disputed <input type="checkbox"/> Yes <input type="checkbox"/> No



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## Contract

Regular Commission will be billed at the prevailing rates and/or deducted from funds available. The dentist agrees to report immediately every payment, or credit to the patient's account. Commission applies to payments made to the agency or the dentist, or on any other valuable consideration including payments from insurance companies. All Court costs are charged to the dentist over and above commission and disbursements are recovered from the debtor upon collection commission free. Court action will not commence without the written authorization of the dentist. A 10% fee will be charged if an account is withdrawn and must be received by the Agency prior to releasing the account. The Agency, under this agreement, has power of attorney to endorse all cheques received by the agency that are made payable to the dentist. The dentist has obtained consent from the patient to collect, use, retain, and disclose personal information for the purposes of collecting the above account(s) and hereby authorizes Credit Bureau Collections Ltd. to use this information to assist in the collection effort. The dentist acknowledges that it has been provided with a Client Handbook. Payments received by the dentist and not reported to the agency within 7 days will be subject to higher commission. The undersigned has read and agrees to these terms & conditions.

*Please tell us where to send your cheque...*



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 P.O. Box 337, Barrie, Ontario L4M 4T5

**Barrie (705) 722-3441 (705) 722-5434**  
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\_\_\_\_\_  
 Signature Date

\_\_\_\_\_  
 Dentist Name

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City Prov Postal

\_\_\_\_\_  
 Phone Number Fax Number