

CORY M. WILLIAMS, DDS
1125 Medical Center Drive
Wilmington, N. C. 28401

I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance.

I understand that I may incur an 18% finance charge if my balance goes beyond 60 days.

I assign dental benefit payments to be paid directly to Dr. Cory M. Williams, DDS from my insurance company.

I give permission for my dentist and his/her clinical team to take any necessary diagnostic films, photos, or study models to properly enable complete diagnosis and treatment.

Date: _____

Signature: _____