Carmel Professional Dentistry

Assignment of Insurance Benefits Agreement

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand that the contract regarding your dental benefits is between you, your employer and your insurance company. The following provisions identify our policies governing insurance claims.

By initialing each statement below, I am agreeing to the terms and conditions set forth in this agreement.

1. **Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important to understand that this does not eliminate your financial obligation for your treatment. _____**

2. **We require you to sign this form and any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payments directly to our office. _____**

3. **We require you to pay the co-insurance amount, (which is the amount not covered by your insurance company) at the time we provide service to you. _____**

4. **Insurance payments ordinarily are received within thirty (30) to sixty (60) days from the time of filing. If your insurance company has not made payment to our office within sixty (60) days, we will ask you to pay the balance due at that time. You will then be responsible for seeking reimbursement from you insurance company. _____**

5. **Our office does not guarantee that your insurance company will pay for treatment that you receive from our office. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying in full at that time. _____**

6. **0ur office will not enter into a dispute with your insurance company over any claim. We will provide any necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company. _____**

I have read and understand the above conditions. I hereby authorize my insurance company to pay my dental benefits directly to the doctor.

_____ _____

Signature of Patient or Responsible Party **Date**