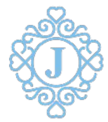

JOSEPH
FAMILY DENTAL

Assignment of Benefits Form

Financial Responsibility

I understand that I am financially responsible to Joseph Family Dental for any charges not covered by health care benefits. It is my responsibility to notify Joseph Family Dental of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Joseph Family Dental and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products and services received

In certain circumstances, insurance companies may send a check for services provided by Joseph Family Dental directly to the patient. In such cases, the patient agrees to endorse and send such a check to Joseph Family Dental. If the patient deposits such a check into a personal account, the patient agrees to send a personal check for the equivalent amount to Joseph Family Dental within 10 days of having deposited the check from the insurance carrier.

Assignment of Benefits

I hereby assign all dental benefits, to include major dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance, and other health/medical plan to issue payment directly to Joseph Family Dental.

Authorization to Release Information

I hereby authorize Joseph Family Dental to: (1) release any information necessary to insurance carrier regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature and this form to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Joseph Family Dental on behalf of myself and/or my dependents, and understand by making this request that I become fully financially responsibl for any and all charges incurred in the course of treatment authorized.

Name of person signing (print):____

Relationship to Insured:____

Signature of Insured:____

Date:____