Pinnacle Peak Dental Care

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand the contract regarding your dental benefits is between you, your employer, and/or your insurance company. The patient has the responsibility to pay our practice for treatment, regardless of the amount we may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- 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 you understand this does not eliminate your financial obligation for your treatment.

- We require you to sign this form and/or any other necessary documents required by your insurance company. This instructs your insurance company to make payment directly to our office.

- We require you to pay the estimated co-payment at the time we provide services. The co-payment is the amount not covered by your insurance company.

- Insurance payments typically are received within thirty to ninety days from the time of billing. If your insurance company has not made payment to our office within ninety days, we will ask you to pay the balance due. You will be responsible for seeking reimbursement from your insurance company.

- **Our office does not guarantee your insurance company will pay for treatment you receive from our practice**. We perform routine insurance billing procedures upon verification of coverage. **If your claim is denied, you will be responsible for paying the full amount of services rendered.**

- Our office will not enter into a dispute with your insurance company over any claim, although we will provide the patient with any necessary documentation required by the insurance company to sort out any disputes. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately the patient's responsibility to resolve any dispute over payment 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 PROVIDING DOCTOR.

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Signature of Patient/Responsible Party: Date:

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Printed Name: