Armando A. Battista D.D.S., P.C.
541 North State Road
Briarcliff Manor, NY 10510

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, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

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 to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
2. We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office. If the insurance company will not pay us directly (because doctor is not a contractual provider), then the patient will be expected to pay for services in full at the time of service.
3. We require you to pay the copayment, 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 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
5. Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied you will be responsible for paying the full amount at that time.
6. Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the 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
7. Returned checks and balances older than 60 days may be subject to collection fees and finance charges at a rate of 1.5% per month (18% annually). Additionally, our office will charge you for broken appointments and appointments cancelled without 48 hours advance notice.

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If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

If you wish to have your dental treatment preauthorized, please initial here _____

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

I AUTHORIZE YOU TO DEBIT MY CREDIT CARD IF YOU HAVE NOT RECEIVED PAYMENT FORM MY INSURANCE COMPANY WITHIN 60 DAYS OF RECEIVING TREATMENT.

Print Name	Credit Card and Number	Expiration Date	Code
_____	_____	_____	_____

_____ _____

Signature of Patient/
Responsible Party

Date