



Assignment of Benefits Form

Name of Patient (print) _____

Social Security Number _____

I request that payment of authorized insurance benefits be made on my behalf to the organization listed below for any services provided to me by that organization.

I authorize the release of any dental or other information necessary to determine these benefits or the benefits payable for related services to the organization, my insurance carrier or other medical/dental entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my dental care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. **I understand that any treatment plan estimate given to me is merely an estimate and not a guarantee of the amount to be paid by the insurer.** I am responsible for the entire bill or balance of the bill as determined by the organization and/or my dental 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/services received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the **Health Insurance Portability and Accountability Act (HIPAA)** to ensure that I have been made aware of my privacy rights.

ORGANIZATION

Joe Isaacson, DDS
3621 NW 63rd Suite H
Oklahoma City, Oklahoma 73116

Name of person signing below (print): _____

Relationship to insured: _____

Signature of Insured or Parent/Guardian: _____

Date: _____