BURBA DENTAL PARTNERS

Advanced Cosmetic Dentistry

Dr. Randy Burba, D.M.D. & Dr Stanley Burba, D.D.S

ASSIGNMENT OF BENEFITS AND MY RESPONSIBILITY

I, _____understand that services rendered to me by Providers at Burba Dental Partners are **my financial responsibility** and that the Provider will bill my insurance company as a courtesy.

I authorize my insurance company to pay my benefits directly to Burba Dental Partners and I understand that **I will be fully responsible for any outstanding balance on my account**. This is a direct assignment of benefits under my policy.

I have been given the opportunity to pay my estimated deductible and co-insurance portion at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my Insurance Company policy.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also authorize provider to initiate a complaint to the insurance commissioner for any reason on my behalf.

I also understand that should my insurance company send payment to me, I will send the payment to Burba Dental Partners within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their money. Should the insurance company forward payment to me, or should I owe additional money after the claims for any treatment performed have been processed I agree to pay for any balances owed promptly or be subject to the collection process and any fees associated.

**In additional, to avoid inconvenience and additional fees, I may choose to authorize Burba Dental Partners to facilitate payment utilizing a credit card number on file to resolve balances owed: Yes or No*

Dated_____

Witness_____

Signature of Policyholder/ Patient /Guardian and Printed Name

_____ _____