ASSIGNMENT OF BENEFITS FORM

NewAgeDental
1250 Greenwood Ave. Suite #2
Jenkintown, PA 19046
T:(215) 774-5500 F:(267) 6262054
www.newagedentalpa.com

Insurance:	**Subscriber:**
ID #:	**Group #:**

I, _____, understand that services rendered to me by _____ 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 NewAgeDental and I understand that I will be fully responsible for any outstanding balance on my account. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

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

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 understand that should my insurance company send payment to me, I will forward the payment to NewAgeDental 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 monies. In the event patient receives any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or payment to the provider. Any violations of this agreement will, at the provider's election, terminate patient charge privileges with the provider and bring any balance owed by patient to provider immediately due and payable.

To avoid the aforementioned additional cost and inconvenience, I have been afforded an opportunity to release credit card information to be retained securely (and in accordance with all federal, state, and local privacy regulations) on file by the provider. I have chosen to (*circle and initial*): **ACCEPT** _____ / **REFUSE** _____ this option. By allowing my credit card information to be retained, in the event that I receive insurance payment(s) for services rendered by NewAgeDental but fail to forward said payment(s) to the Provider within 48 hours, I hereby authorize NewAgeDental to facilitate payment utilizing my credit card information to resolve the balance. A photocopy of the Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Date _____ Witness_____

Signature of Policyholder _____
Patient or Guardian_____