VALLEYWIDE DENTAL, INC.

DR. ROBERT HAZE, D.D.S.

Office use only:

Date: _____

Patient: _____

I.D.#: _____

Group #: _____

Insurance Carrier: _____

I _____ , understand that services rendered to me by **Valleywide Dental, Inc.** 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 **Valleywide Dental, Inc.** 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 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 or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my Dental/Medical Insurance.

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 forward the payment to **Valleywide Dental, Inc.** 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 Provider. Any violations of this agreement will, at the Provider's election, terminate Patient charge privileges with Provider and bring any balance owed by Patient to Provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize **Valleywide Dental, Inc.** to facilitate payment utilizing the credit card number on file to resolve the balance.

I understand that any unpaid portion from my insurance company is my responsibility and due immediately to **Valleywide Dental, Inc.**

Dated _____ Witness _____

_____ _____

Signature of Policyholder Patient Guardian Printed Name

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