Adam Brown, DDS
FAMILY, COSMETIC & RESTORATIVE DENTISTRY

704 S Sutherland Ave
Monroe, NC 28112
704-289-9519 Office 704-289-9104 Fax

Assignment of Benefits

Name of Insured (print): _____

Social Security Number: _____

I request that payment of authorized insurance benefits be made on my behalf to Adam Brown, DDS, PLLC for any services and/or treatment provided to me by said PLLC.

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

I understand that I am financially responsible to the PLLC for any charges not covered by dental care benefits. It is my responsibility to notify the PLLC 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 am responsible for the entire bill or balance of the bill as determined by the PLLC and/or my dental care 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 services received.

By signing this document, I also acknowledge that I have received a copy of the organization 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

Adam Brown, DDS, PLLC
704 S Sutherland Ave
Monroe, NC 28112

Name of person signing (print):_____

Signature: _____ Date: _____

Relationship to Insured: _____