

DR. SHAHRAM YAZDANI DENTISTRY PROFESSIONAL CORPORATION

ASSIGNMENT OF BENEFITS / CANCELLATION AGREEMENT

Assignment of Benefits:

It is important that you understand that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation that you have with Dr. Shahram Dentistry Professional Corporation is to pay for treatment— regardless of the amount that may or may not be reimbursed by your insurance company. Our office will accept an assignment of benefits from your primary insurance company with the following provisions:

- i. We will complete insurance information forms and submit all dental claims on your behalf; however, we **do not** accept responsibility for the outcome of the transaction.
- ii. Please be advised that your employer may have chosen not to allow assignment of benefits. In this case, we will be obliged to take payment in full at the time of your appointment – unless you have made prior arrangements with our Treatment Coordinator for bi-weekly or monthly payments.
- iii. In order to offer you the privilege of assigning your benefits to our office you are required to provide a **valid credit card number**, which will be stored securely on your file. This card number will be used to settle any outstanding account balances over **60 days**. If the credit card is not valid or is expired and we are unable to reach you after 60 days, the account in arrears will be sent to a collection agency.
- iv. When our office sends your claim, your insurance company will respond in one of two ways:
 - a. **Explanation of Benefits**, which outlines the specifics of your treatment and verifies the extent to which you are covered. At this time, we require you to pay the co-payment—the amount **NOT** covered—in full.
 - b. **Claim Acknowledgement**, which does not verify the extent to which you are covered. At this time, we will require a credit card on file.
- v. Our office does not guarantee that your insurance company will pay for the treatment that you receive. If your claim is denied, **you are required to pay the total balance due**.
- vi. Our office will cooperate fully with the regulations and requests of your insurance company; however, we will **NOT** enter into a dispute with your insurance company over a claim. You are responsible for resolving any / all disputes over payments made or not made by your insurance company.

Cancellation:

We require **48 hours notice for any change or cancellation to your dental reservation. If multiple cancellations occur within the 48 hour short notice period, we reserve the right to charge a cancellation fee (all proceeds are donated to charity) OR we may refrain from scheduling future appointments. We recognize the time of our clients and staff is valuable and have implemented this policy for this reason.**

Agreement:

I have been given adequate time to read and have read the preceding terms and conditions. I understand and agree to the above policies, as indicated by my signature below:

Patient's name(s) (please print)

Insured signature (Patient signature if insurer not present)

Date

Witness signature

Date