Assignment of Benefits Form

Angela Hilton-Foley, DMD, PA Date:_____

Patient Name: _____
Address _____
City _____State _____ Zip_____
Phone: _____

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

I, _____understand that services rendered to me by Angela Hilton-Foley and her associates, 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 Angela Hilton-Foley, DMD, PA and I understand that I will be fully responsible for any outstanding balance on my account.

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. Rather than pay in full at this time, I have chosen to assign the benefits for the estimated portion remaining, 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.

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 claim. I also authorize the 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 Angela Hilton-Foley, DMD, PA 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 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 Angela Hilton-Foley, DMD,PA to facilitate payment utilizing the credit card number on file to resolve the balance.

Dated: _____ Signature of Policyholder/Patient/Guardian: _____

Printed Name: _____

Witness: _____