National Provider Compliance Corporation- Insurance Procedure and Policy

Gateway Dental Care
5656 South Power Road Ste. 129
Gilbert AZ 85295
480-279-4888

I, ________________________________ understand that service rendered to me **Dr. Barber** are my financial responsibility and that the provider **will bill my insurance company**, that **Dr. Barber** has on file as a **Courtesy**. I authorize my insurance company to pay my benefits directly to **Dr. Barber** .

I understand that I will be fully responsible for any outstanding balance on my account.

_________ (INITIAL) The Treatment plan that is presented is NOT a definite amount patient owes for services, insurance company may downgrade or pay less than estimated. This is the patient's Responsibility.

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 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 that is on file.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated cost 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 **Dr. Barber** within 48 hours. I agree that if I sail 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 any 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 coast and inconvenience, should be insurance company forward payment to me, I authorize **Dr. Robert Barber** to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as affective 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 Policy Holder/ Responsible party

______________________________ Patient or Guardian