Assignment of Benefits

(Direct Billing Agreement)

Our office can do direct billing for you ~ (we will submit the insurance claim and have the monies come here), however there are some things that we need to make you aware of and ensure that we are in agreement before we do so.

- Insurance companies do not perceive us as a representative of you. They can refuse to provide us information. They can send the payment to you in error. They may require your signature on documents, and we require a commitment from you to work as a team to ensure that payments are made and that accounts are kept in good standing. We will act in good faith and ask the same of our patients.
- If you receive an insurance cheque that should have come to us, we ask that you forward it to our office in a timely fashion (including a copy of what was covered). If you are paid in error, please be considerate and ensure that the monies come to us.
- If the insurance company sends something to you to sign, please do so and return to them as quickly as possible ~ any delay delay's payment on your account and if it is an excessive delay you will be responsible to pay the account.
- You are responsible to pay for any co-pay's (portion not covered by the dental plan), any procedures that are not paid in full and any deductibles. Asking us to "waive" these fees constitute as insurance fraud and we cannot comply with that request (please don't ask ~ thank you).
- If your plan doesn't pay ultimately it is your responsibility for your account. We cannot be held accountable for any portions not covered. It is logistically impossible for us to know everything about everyone's insurance plan. If you want us to know the details of your plan please bring in your plan booklet and we will do our best to assist you. If you would like an estimate for cost of treatment please ask ~ we'd be happy to help you with that.

I, _____ fully understand and agree to everything listed above and I would like Britannia Dental Centre (Dr N. Parsa) to send in dental claims on my behalf and ask that the benefits go to the office. I agree that I will pay in full any portions not covered/paid for by my insurance company/companies. I also agree that I will forward any payments/documentation to my dental office to assist in keeping my account in good standing.

Signed: _____

Date: _____

Witness Signature: _____

Address: 2942 Carling Avenue, Ottawa, ON, K2B 7J7 * **Phone** 613-820-2999 * **Email** office@drparsa.ca