WONDER
FAMILY DENTAL & DENTURES

19410 8th Ave NE Suite 102 Poulsbo, WA 98370
Phone: (360) 779-1566 | Fax: (360) 779-6879

INSURANCE ASSIGNMENT OF BENEFITS

I understand that services rendered to me by Dr. Kaylee Wonder are my financial responsibility and that *the dentist will bill my insurance company as a courtesy.* ***I authorize my insurance company to pay my benefits directly to Dr. Kaylee Wonder and I understand that I will be fully responsible for any outstanding balance on my account. 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 coinsurance 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.

I authorize the dentist 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 clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Dr. Kaylee Wonder within 48 hours. I agree that if I fail to send the payment to Dr. Kaylee Wonder 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 that the patient receives any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or payment to my dentist. Any violations of this agreement will, at dentist's election, terminate patient charge privileges with dentist and bring any balance owed by patient to dentist immediately due and payable.

I authorize the dentist 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.

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