Green Hills
DENTAL GROUP
John L. Farringer III, D.D.S.

ASSIGNMENT OF BENEFITS, HIPAA AND PAYMENT POLICY, AUTHORIZATION TO RELEASE INFORMATION

I do hereby authorize Dr. John Farringer, known hereafter in this document as DJF, to furnish my insurance company(s), attorney, or legal representative all information, which said parties may request concerning my illness or injury. I hereby assign to DJF all money, which I recover from any source on account of the accident or illness for which I am being treated by DJF, not to exceed my indebtedness to said clinic. I further agree and accept as follows:
-That insurance is a contract between the patient and the insurance company and DJF only bills insurance as a courtesy to patients and that I am financially responsible to DJF for ALL charges for services rendered.

I recognize that DJF will bill and attempt to collect from my insurance company as a courtesy. I fully understand that DJF may not accept my insurance company usual and customary fees (UCR) as payment in full. This may lead to my receiving a bill for deductibles, co-payments and co-insurances. I agree to pay any such balance. I understand that it is my responsibility to obtain all necessary referrals from other doctors as required by my insurance, and this must be done before I can see Dr. Farringer or his staff. I am responsible for understanding my individual insurance policy and benefits prior to seeking services.

Although I may be represented by an attorney on matters related to the illness/injury of which DJF has rendered services to me, I must still keep my account current and paid in full.

If my account becomes delinquent and is referred to an attorney or collection agency for collection, I agree to pay a 40% attorney or collection fee, any court costs incurred by DJF, in addition to the outstanding balance of the account.

I fully understand that while DJF is willing to send an insurance claim to my insurance company, DJF will not be responsible for lost claims or claims that did not arrive at my insurance. I understand that if payment from my insurance is not received by DJF within 75 days from the date of service, the TOTAL balance will become my responsibility and will be due immediately. All accounts that are 90 days old will be sent to collection. Patients are encouraged to stay in touch with their insurance carrier as to the status of their claim.

I understand that if this practice is sold, splits or merges, the new owner will acquire my medical records for the purpose of disclosure for health care operations.

I understand that any adjustments needed for my appliance are included in the up front cost for the for the first 3 months.

This agreement is in addition to any other agreement, which I may have with DJF. I have read this document, understand it fully and agree to the terms and conditions.

HIPAA

I have acknowledged a copy of this office's Notice of Privacy Practices posted on the waiting room wall and available on this site. If you would like a copy of these privacy practices, please ask for one at the at the front desk.

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Patient/Parent/Guardian Signature Today's Date