Southern Cross Dental
1855 South Nevada Ave.
Colorado Springs, CO 80905
(719)471-1717

Assignment of Benefits

I hereby instruct and direct_____ Insurance Company to pay by check made payable to Southern Cross Dental and mailed to the above address or if my current policy prohibits direct payment to doctor, I will transfer endorsement or issue new payment to Southern Cross Dental, and mail it to the above address. This payment is for the professional or dental expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE 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 the insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated this _____ day of _____, 20_____.

_____ _____

Signature of Policyholder Signature of Claimant, if other than Policyholder

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Office Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees. Financial policy is your responsibility.

ALL patients must complete our "Patient Information Forms" before seeing the doctor.

Full payment is due at the time of service unless prior arrangements have been made.

We accept cash, checks, money orders, VISA, MasterCard and Discover.

For patients of record with insurance, the co-payment and deductible are due at time of service.

For Emergency patients (not regular patients of the Practice) full payment is due at time of service.

The office will provide you with a "Superbill" to submit to your insurance company for reimbursement.

Our office will make every effort to be punctual. In the event the Doctor runs behind schedule due to emergencies or complications not expected; you will be informed and will be given the option to reschedule or return at a later time. We recognize your time is as valuable as our time. Whatever your decision, be assured that you will receive the quality, caring treatment you deserve.

Failure to provide 24 hours of notice prior to cancellation will result in a $50 fee for each hour of appointment time in our schedule.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

I, _____ have received a copy of this office's Notice of Privacy Practices.

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (leave blank if acknowledgement could not be obtained).

1. Individual refused to sign
2. Communication barriers prohibited obtaining the acknowledgement
3. An emergency situation prevented us from obtaining acknowledgement
4. Other (Please Specify)

Printed Name:
Signature:
Date: