Please read and sign this statement before we agree to accept assignment directly from your insurance company. This avoids any misunderstandings and facilitates processing of your insurance claim.

If you have any questions, please ask us. Thank you.

I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment within 90 days, I will be responsible for the full amount owed to Dr. Earl K. Bogrow, D.D.S.

I understand and agree that if upon payment by the insurance company, there is a remaining balance, I am responsible for the amount in full at that time. If I feel I cannot pay it in full, I can request a written financial agreement (terms to be discussed at that time).

Thank you.

X ______________________________
SIGNATURE OF RESPONSIBLE PARTY

X ______________________________
SIGNATURE OF FINANCIAL COORDINATOR

____
DATE

www.bogrowandassociates.com
28411 Northwestern Hwy. • (Wyatt Building) • Suite 225 • Southfield, MI 48034
(248) 827-1900 • Fax: (248) 827-0949

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Something to SMILE about
BOGROW & ASSOCIATES
Complete Restorative & Cosmetic Dentistry

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

PATIENT NAME ____
LAST FIRST INITIAL

I authorize the office of Bogrow & Associates to submit claims for payment for services to the health care service plans or insurance companies name below, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by my insurance benefits.

1. ____
INSURANCE COMPANY

2. ____
INSURANCE COMPANY

3. ____
INSURANCE COMPANY

____
NAME (PATIENT, PARENT OR GUARDIAN

X ______________________________ ______________
SIGNATURE (PATIENT, PARENT OR GUARDIAN DATE

Signature is valid for _____ years from the above date, unless revoked by me at an earlier date.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME ____
LAST FIRST INITIAL

I authorize the office of Bogrow & Associates to provide any insurance company, health care service plan, self insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

____
NAME (PATIENT, PARENT OR GUARDIAN

X ______________________________ ______________
SIGNATURE (PATIENT, PARENT OR GUARDIAN DATE

Signature is valid for _____ years from the above date, unless revoked by me at an earlier date.

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