

**Queensboro Oral
Surgery & Implants**

www.queensborodentalimplants.com

(Patient's Name)

Assignment Of Benefits / Authorization To Release Information

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Queensboro Oral Surgery & Implants, for any covered services furnished by Queensboro Oral Surgery & Implants. I agree to pay to Queensboro Oral Surgery & Implants, the deductible and/or coinsurance on my claim.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

I further certify that the information provided by me is true, accurate and complete.

If this is a private claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, or I fail to provide within thirty (30) days the information necessary to submit the claim for payment.

Patient/Representative Signature: _____ Date: _____

If Representative, please complete below:

Printed Name: _____

Address: _____

Relationship to Patient: _____

Reason for Patient's Inability to Sign: _____

For Notice of Privacy Practices only, describe the Personal Representative's authority to act on behalf of the patient.
