Financial & Cancellation Agreement

I, _____, understand that services rendered to me by Canton Dental Associates are my financial responsibility and that the provider will bill my insurance company _____, as a courtesy. I authorize my insurance company to pay my benefits directly to Canton Dental Associates 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.

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 accurate information to facilitate the prompt payment of the claim by _____ (insurance company).

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

I authorize Canton Dental Associates 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.

Out of courtesy to Canton Dental Associates I will provide at least 24 hours prior notice to the Practice to cancel an appointment. If I fail to attend an appointment without providing at least 24 hours prior notice of cancellation I will be subject to the missed appointment fee of $59.00

_____ _____

Signature of policyholder Patient or Guardian

_____

Date