Assignment of Benefits Form

Financial Responsibility

I understand that I am financially responsible to Ahmed U Metwally DMD PLLC for any charges not covered by health care benefits. It is my responsibility to notify Northside Dental of any changes in my health care coverage. In some cases, exact insurances benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as part of them are denied for payments. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products and services received.

In certain circumstances, insurance companies may send a check for services provided by Ahmed U Metwally DMD PLLC directly to the patient. In such cases, the patient agrees to endorse and send such a check to Northside Dental . If patient deposits such a check into a personal account, the patient agrees to send a personal check for equivalent amount to Ahmed U Metwally DMD PLLC within 10days of having deposited the check from the insurance carrier.

Assignment of Benefits

I hereby assign all dental benefits, to include major dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, Private Insurance and any other dental plans, to issue payment directly to Ahmed U Metwally DMD PLLC.

Authorization to Release Information

I hereby authorize Ahmed U Metwally DMD PLLC to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the courses of examination or treatment; and (3) allow a photocopy of any signature and this form to be used to process insurance claims for the period of lifetime. This order will remain in effect revoked by me in writing.

I have requested medical services from Northside Dental on behalf of myself and/or my dependents, and understand by making this request that I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

Name of Person signing (print): _____

Relationship to Insured: _____

Signature of Insured: _____

Date: _____