Assignment of Benefits Form

J. Keith Mitchell, DDS 3114 N. O'Connor Rd, Irving, TX 75062 972-252-3020

I, _____, understand that services rendered to me by Dr. Mitchell 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 Dr. Keith Mitchell, DDS 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 relevant and accurate information to facilitate the prompt payment of the claim by my insurance company. I authorize Dr. Mitchell's office to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me; I will forward the payment to Dr. Mitchell within a timely manner.

I authorize Dr. Keith Mitchell, DDS 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. A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____

Signature of policyholder, Patient or Guardian Date

_____

If guardian, print name and relationship to patient