diamond dental
SLEEP SOLUTIONS

# Patient Intake Form

info@diamondsleepsolutions.com | 2983 Long Beach Road, Oceanside, NY 11572
Phone. 516.778.9296 | Fax. 516.299.9117

## Patient Authorization, Assignment of Benefits & Financial Agreement

In return for the services provided by Diamond Dental Sleep Solutions, (the "Practice") I understand that all applicable copayments and deductibles are due at the time of service. I will pay my account at the time service is rendered to me or will make financial arrangements satisfactory to the Practice for payment. I agree to be financially responsible and make full payment for all charges not covered by my insurance company, including in instances where my coverages lapses or if I fail to give the requisite insurance information to the office. I authorize my insurance benefits to be paid directly to the Practice for services rendered. I authorize representatives of the Practice to release pertinent information to my insurance company when requested or to facilitate payment of a claim. I assign to the Practice any benefits of any type under any policy of insurance that insures me or any other party liable to me. In the event I receive payment from the insurance company for services rendered by the Practice and fail to remit such payment to the Practice immediately then I acknowledge and agree that I will be responsible for any fees, including legal fees associated with Dental Sleep Solutions' collection efforts from me. If my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. If my account is delinquent, I may be charged interest at the legal rate. I agree to be primarily responsible for the payment of the Practice's bill.

I read and agree to all of the above.

Beneficiary Signature or Authorized Party: _____

Date:_____