zam DENTAL

Offices of M. Zamora D.M.D.

Release of Information to Insurers and Assignment of Benefits

*Must be signed by all new patients with insurance and those who expect to obtain insurance

To the extent permitted by law, I consent to Zam Dental use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to Zam Dental of the dental benefits otherwise payable to me.

___ I authorize use of this form on all my insurance submissions
___ I authorize release of information to all my insurance carriers
___ I understand that I am responsible for my bill
___ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
___ I authorize payment directly to my doctor
___ I permit a copy of this authorization to be used in place of the original

Accepted and agreed to by:

_____

Printed name Signature of Patient Date

ZamDental03/2014
Scanned on:_____ By:_____