JAMES R. ZORA, D.MD.

Family & General Dentistry

Zora Family Dental
555 East Bruceton Rd.
Pittsburgh, PA 15236

Assignment of Benefits Form

I hereby assign all dental benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment(s) directly to Zora Family Dental for dental services rendered to myself and/or my dependents regardless of my insurance benefits, if any.

Authorization of Release Information

I hereby authorize Zora Family Dental to:

1. release any information necessary to insurance carrier(s) regarding my treatment
2. process insurance claims generated in the course of examination and treatment
3. allow my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing

I have requested dental services from Zora Family Dental on behalf of myself and/or my dependents and understand that by making this request, **I become fully responsible for any and all charges incurred in the course of treatment authorized**. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred that my insurance does not cover. A photocopy of this assignment is to be considered as valid as the original.

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as assessments and certifications.

By signing this document, I also acknowledge that I have received the Notice of Privacy Practices. I understand this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime at the address above to obtain a copy of the new Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient/Parent (if under 18 years old) Signature: _____

Date: _____