**Patient Name:** ______________________ **BIRTHDATE:** _______________

## ASSIGNMENT OF BENEFITS AND COLLECTIONS POLICY

### ASSIGNMENT OF BENEFITS

I hereby authorize direct payment to Dakota Child and Family Clinic of any medical benefits payable to me for the services provided at Dakota Child and Family Clinic.

I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done.

### COLLECTIONS

I understand Dakota Child and Family Clinic will make every attempt to process my insurance claims. If there are any monies due by myself that are not paid within 90 days they will be considered for collections. If my account is turned over to collections there will be an additional charge of up to 35%.

X_____________________________________________________________

**Patient Signature or Signature of Guardian or Parent** **DATE**

### RECORDS RELEASE

**I hereby authorize Dakota Child and Family Clinic to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as is dictated by the insurance payor.**

X_____________________________________________________________

**Patient Signature or Signature of Guardian or Parent** **DATE**

**My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for Dakota Child and Family Clinic.**

X_____________________________________________________________

**Signature of Patient/Client or Personal Representative** **DATE**

**If signed by personal representative, relationship to patient:** ____________

*A copy of the Notice of Privacy Practices for Dakota Child and Family Clinic is also available on the website: www.dakotachildandfamilyclinic.org