CROSSINGS CLINIC
dental sleep apnea center

LOUISVILLE DENTAL
SLEEP MEDICINE, PLLC

Authorization and Assignment Agreement

In consideration of **Crossings Clinic Dental Sleep Apnea Center** undertaking to treat me, I agree to the following:

Authorization to Release Information: I authorize the release of a full report of examinations, findings, diagnosis, treatment program, etc., to any referring and/or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies for legal documentation to process claims.

Assignment of Cause of Action: In the event any insurance company is obligated by contractual agreement to make payment to me or to the above named doctor, by assignment, I hereby assign and transfer to you the cause of action that exists in my favor against any such company. I understand that whatever amount you do not collect from insurance proceeds, I personally will owe you and agree to pay in a current manner.

I understand that I am responsible for any insurance payment that is over 90 days old.

Patient Signature _____

Date _____

5140 Charlestown Road • New Albany, IN 47150 • Phone (812) 941-9000 • Fax (502) 458-7797
3935 DuPont Circle, Suite C • Louisville, KY 40207 • Phone (502) 458-7476 • Fax (502) 458-7797
www.crossingsclinic.com