SAMPLE NON-ASSIGNMENT OF BENEFITS ACKNOWLEDGEMENT AND PATIENT PAYMENT AGREEMENT

Disclaimer and Important Notice for the Practice: This is a **sample conceptual template** provided solely for training and educational purposes. It is **not** a legally reviewed document and is **not** intended for direct use by any practice without independent legal review.

Before using, modifying, or implementing any version of this form, the practice must:

- consult with a **licensed attorney** in their state,
- verify applicable **state and federal laws** governing payment agreements, financial arrangements, and credit card authorizations,
- confirm whether a patient's insurance plan **allows, limits, or prohibits** assignment of benefits,
- review all relevant **PPO/provider agreements** for restrictions on patient communication or reimbursement handling,
- ensure compliance with **PCI-DSS* requirements** if accepting credit cards,
- determine whether this type of agreement is considered a **consumer credit contract** in the practice's state,
- confirm the practice's payment processor supports this arrangement,
- and implement all legally required notices, disclosures, and protections as determined by counsel.

MGE: Management Experts, Inc., Byrsa Publishing, LLC, and the authors assume **no liability** for the use, modification, or distribution of this template. The practice is **solely** responsible for creating and implementing a legally compliant version.

*= **PCI-DSS – Payment Card Industry Data Security Standard Compliance:** A security standard that requires credit card information to be stored and handled safely. Only approved, secure payment processors (not the dental office) are allowed to store full credit card numbers.

SAMPLE NON-ASSIGNMENT OF BENEFITS ACKNOWLEDGEMENT AND PATIENT PAYMENT AGREEMENT TEMPLATE

*(DO **NOT** USE WITHOUT ATTORNEY REVIEW)*

Patient Name: _____

Date: _____

Insurance Plan: _____

1. Insurance Payment Process Acknowledgement

I understand that my dental insurance plan **may send payment directly to me** rather than to the dental office. If this occurs, I understand that I remain responsible for paying any balance owed to the practice for services I receive.

2. My Responsibility for Payment

I understand and agree that:

- I am financially responsible for all charges for services provided to me.
- If my insurance company sends payment directly to me, I agree to forward that payment to the practice.
- If neither I nor the practice has received insurance reimbursement within **[30 / 45] days** of the date of service, I agree to pay any remaining balance directly to the practice.
- I will notify the practice promptly if I receive payment from my insurance company or if I believe insurance payment has been delayed.

3. Authorization for Approved Payment Method

If insurance reimbursement is sent to me and I do not provide that payment to the practice within **[30 / 45] days**, I authorize the practice to apply an **approved, securely stored payment method** to any outstanding balance related to my treatment.

Payment Method Authorized (select one):

☐ Previously authorized card stored securely through the practice's PCI-compliant payment processor

☐ Another approved payment method: _____

☐ I prefer to bring any insurance payment directly to the office

Note: The practice does not store full credit card numbers. All payment information, if authorized, is stored through the practice's PCI-compliant payment processor.

4. Agreement to Communicate

I agree to promptly communicate with the practice regarding:

- any insurance payment I receive,
- any delay in reimbursement,
- and any questions or concerns about my balance.

5. Signature

By signing below, I acknowledge that I have read and understand this agreement.
I understand that this form does not alter my insurance benefits and applies only to how payment for my dental care will be handled if my insurance plan issues reimbursement directly to me.

Patient Signature: _____ Date: _____
Practice Representative: _____ Date: _____