HIDDEN LAKES
DENTAL CARE

ASSIGNMENT OF BENEFITS

Patient:_____
Employer:_____
SS#/ID#_____

I hereby instruct and direct _____Insurance Company to pay by check made out and mailed to:

Hidden Lakes Dental Care, P.C.
680 W. Boughton Rd., Ste. 100
Bolingbrook, IL 60440

Or

If my current policy prohibits direct payment to Hidden Lakes Dental Care, P.C., I hereby also instruct and direct _____Insurance Company to make out the check to me and mail it as follows to:

Hidden Lakes Dental Care, P. C.
680 W. Boughton Rd., Ste. 100
Bolingbrook, IL 60440

for the professional or dental expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Hidden Lakes Dental Care, P.C. to initiate a complaint to the appropriate Insurance Commissioner for any reason on my behalf.

Dated this _____ day of _____, _____.

_____
Signature of Policyholder or Signature of Claimant, if other than Policyholder