ASSIGNMENT OF RIGHTS AND BENEFITS

Patient Name _______________________________________ Date of birth ________________________

Policy Holder's Name _________________________________

Insurance Co. _______________________________________ Claim/Group No. ____________________

Employer ____

1. I hereby assign all rights and benefits under my insurance contract with ____________________________
   Dental Insurance Company
   to Dr. Herrera for the purpose of determining the details of the benefits of this policy and obtaining payment for services given.
2. This assignment further permits Dr. Herrera to obtain from my insurance company all information necessary for the determination of benefits allowed under the contract and permits the direct disclosure to Dr. Herrera of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered.
3. This assignment shall allow Dr. Herrera to take all action necessary to obtain the benefits I have, in good faith, been promised by my insurance company.
4. All benefits are to be paid directly to: Concord Dental Care, G. Allen Herrera, DDS
   5167 Clayton Road, Ste. C, Concord, California 94521
5. If my current policy prohibits direct payment to Dr. Herrera, then I hereby also instruct and direct you to make out the check to me and mail it care of: Concord Dental Care, G. Allen Herrera, DDS
   5167 Clayton Road, Ste. C, Concord, California 94521
6. A photocopy of this assignment shall be considered as effective and valid as the original.
7. I further authorize Dr. Herrera to initiate a complaint to the Insurance Commissioner's office for any reason on my behalf.
8. This assignment shall remain in effect for the duration of treatment and any additional time necessary to secure full payment for services rendered.
9. This is a direct assignment of my rights and benefits under this policy.

The undersigned certifies that he/she has read and understands the foregoing, and accepts its terms.

____ ______________________

Signature of Policy Holder *Date*

____ ______________________

Signature of Patient (if other than Policy Holder) *Date*

Assignment means "to give." This form means you are giving this office full authorization to act on your behalf in obtaining information and collecting money for your health care at this office. You are still responsible for the full balance of your care including deductibles, co-payments and any amounts your insurance company will not pay.