

# **Camino Dental Group**

1328 W. El Camino Real, Mountain View CA 94040. Tel. (650) 962-8773 Fax. (650) 962-8464

## **Assignment of Benefits and Authorization Release**

I hereby authorize and request my insurance company to assign benefits directly to my dentist or dental group insurance benefits otherwise payable to me. If my current policy prohibits direct payment to dentist, I hereby agree to pay the dentist the sum equal to the insurance payment received by me. I shall mail the check as follows:

Payable to : Sheila Tan, DDS, Inc.  
Mail to: Camino Dental Group  
1328 W. El Camino Real Suite #1  
Mountain View, CA 94040

I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, and for any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this Assignment shall be considered as effective and valid as the original.

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**Signature of Patient / Guarantor if minor**

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**Date**