JEFFREY A. HOUSLEY, DDS, MS BRENT S. DOBSON, DDS, MS

YOUR SMILE IS OUR SPECIALTY
BOARD CERTIFIED ORTHODONTISTS

Assignment of Benefits and Authorization Release

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

Payable to: Owasso Orthodontics
Mail to: Owasso Orthodontics
12813 E. 101st Place North
Owasso, OK 74055

I authorize the treatment provider 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.

_____ _____
Signature of Subscriber Date

Subscriber Name: _____

Patient Name: _____

Subscriber D.O.B.: _____

Subscriber SSN or Member ID: _____

Employer: _____

Insurance Company: _____

Insurance Phone: _____

Email to: info@owassoorthodontics.com
Fax to: 918-272-5753