Brenda R. Gentry DDS, PA

302 N. Heatherwilde Blvd. Suite 100
Pflugerville, Texas 78660
Exceeding Expectations
(512)252-SMILe

Date: _____

Patient: _____ Employer:_____

Claim Group:_____ SS#/ID#_____

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

Brenda R. Gentry DDS, PA
302 N. Heatherwilde Blvd. Suite 100
Pflugerville, TX 78660

Or if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:
302 N. Heatherwilde, Suite 100
Pflugerville, TX 78660

For the professional or medical 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 doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ this _____day of _____201___
(Time) (Day) (Month)

_____ _____
Signature of Policy holder Signature of Claimant, if other than Policy Holder

_____
Witness