<u>ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT TO DOCTOR</u>

The undersigned hereby authorizes the insurance manager of Philip G. Polus, D.D.S., P.C., as the undersigned's attorney-in-fact, to apply for, collect and apply to the undersigned's account with their dental insurance carrier, any amount payable to or for the benefit of the undersigned or any member of the undersigned's family under any contract of insurance covering such person for any services performed at the office of Philip G. Polus, D.D.S., P.C.

The undersigned authorizes the release of any requested information to any insurance company, peer review committees, or attorney involved in this case.

The undersigned further authorizes payment directly to Philip G. Polus, D.D.S., P.C. of the insurance benefits payable but not to exceed the actual charges for the covered services. I understand that i am financially responsible for all costs of dental treatment and that interest of 1.5% per month and attorney fees and costs may be imposed in the event of payment default. This authorization shall remain in full force and effect until written notice of its revocation is received by Philip G. Polus, D.D.S.

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct the insurance company to make the check payable to me and mail it as follows:

C/O PHILIP G. POLUS, D.D.S., P.C.
1549 SOUTH COURT STREET
SUITE B
CROWN POINT, IN 46307

DATE: ______________________ SIGNED BY: ____

WITNESS: _________________________________

EMPLOYEE NAME: ___________________________ SOCIAL SECURITY: ____________________

ADDRESS: ____

____ PHONE: ________________________

EMPLOYER (COMPANY) NAME: ____

ADDRESS: ____

INSURANCE COMPANY NAME: ____

ADDRESS: ____

GROUP OR POLICY #: ____________________________ GROUP OR UNION NAME: ____________

WHERE DOES THE CLAIM GO: EMPLOYER_____ INS. COMP. _____ PATIENT_____

SIGNATURE REQUIRED FOR ALL ACCOUNTS THAT CARRY A BALANCE