Matthew S. Ames, DDS, MS & Daniel C. Peterson, DDS, MSD Specialists in Orthodontics and Dentofacial Orthopedics

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## Assignment of Benefits

I,[Subscriber's Full Name]	_ hereby authorize and direct payment of the
[Subscriber's Full Name]	
dental benefits under	which are
[Name of D	ental Insurance Company]
otherwise payable to me, directly to Ames & Peterson Orthodontics, PLLC.	
I understand that the fee for service may not be covered by or may exceed the dental benefits provided under my policy. I understand that I am responsible to the provider of service for the balance of the cost of treatment that is not paid by my insurance company.	
Name of Subscriber:	
	[Please Print]
Authorized Signature:	
Date:	

FOR OFFICE USE ONLY: Ames and Peterson Orthodontics representative: \_\_\_\_\_