Dimples

SUBSCRIBER

Authorization for Signature on File

Authorization of Payment

I _____ hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the office of **Dimples Family Dentistry.**

This "Signature on File" will be valid from this date
and shall expire in one year.
A photocopy of this document may act as an original.

_____ Today's Date

_____ Signature of Subscriber

_____ Expiration Date

_____ Witnessed By

PATIENT

Authorization for Signature on File

Release of Information / Financial Responsibility

I _____ hereby authorize the office of **Dimples Family Dentistry,** to affix my name to any and all claims or documents as related to any and all health benefits due me.

I have been informed of the treatment and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection to this claim.

This "Signature on File" will be valid from this date
and shall expire in one year.
A photocopy of this document may act as an original.

_____ Today's Date

_____ Signature of Patient/Guardian

_____ Expiration Date

_____ Witnessed By