Patient:

_____

Authorization to Release Information

I authorize all health professionals and all healthcare institutions to provide information on behalf of myself and covered dependents to my current Health/Dental plan Administrators and the utilization review organizations with whom my insurance carrier as contracted concerning any and all forms of healthcare treatment. I also give authorization for the release of information/radiographs for the purpose of further dental treatment or second opinion. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Certification of Information

Any person who, knowingly and with intent of defraud or deceive, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime. I hereby certify that the information furnished by me in support of this claim is true and correct to the best of my knowledge.

Authorization to Pay Provider Directly

I authorize payment of benefits directly to the dentist or supplier named herein for the services described on provider claim forms, and/or any attachments submitted to my insurance carrier.

Financial Arrangements:

Disclaimer:

Insurance coverage is estimated. Your actual indemnity may be less. You, the patient are responsible for all amounts not covered by your insurance carrier. Ultimately, you are responsible for all financial obligations for your health/dental care services.

Ultimately, you, the patient/responsible party, are responsible for any charges not covered/paid by your insurance carrier. We suggest you familiarize yourself with your insurance coverage or contact your carrier with any questions/concerns that may arise.

Please sign if you understand and accept this information.

Signature:_____ Date:_____