

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 **Dental Impressions, LLC**.

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 **Dental Impressions, LLC**, 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