Authorization and Release

I certify that I have read and understand the patient information form to the best of my knowledge. The questions on the form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company pay directly to the dentist benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event that this account becomes delinquent and collection agencies are used to collect the debt, I understand that I will be responsible for any and all collection/court costs associated with collecting the debt.

x_____ _____

Signature of Patient, Parent, Or Guardian (if minor) Date

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