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 Associates of Decorah, P.C.

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 Associates of Decorah, P.C. to affix my name to any and all claims or documents as related to any and all health benefits to me.

I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by 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 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

We are happy to process any insurance claim as a service to you at no charge. Please keep in mind that any estimate that we provide to you is only an estimate and that you are responsible for all fees in their entirety.