

AUTHORIZATION FOR SIGNATURE ON FILE

Release of Information/Financial Responsibility/Authorization for Payment

I, _____ and/or _____
Name of Patient(Parent or Guardian if Minor) Name of Insured

Hereby authorize the office of **William L. Walden, DDS, PC** to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with _____.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless 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 under applicable law, I authorize release of any information relating to the claim.

This "Authorization" will be valid from this date. A photocopy of this document may act as an original.

*Please understand that we are billing your insurance company as a courtesy to you, our patient. If your insurance company does not pay the claims in full you will be responsible for any and all balances remaining. As a courtesy to you we will bill the insurance company and provide all necessary documentation to help expedite your claims, after 90 days if the claims have not been paid we will provide you this information and require payment in full by you. By initialing here _____ you accept all responsibility for any unpaid balances.

Signature of Insured

Signature of Patient (Parent or Guardian if Minor)

Today's Date