

general dentistry • periodontics • orthodontics • cosmetic dentistry

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I hereby authorize payment directly to Mapledale Family Dentistry for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

 $I\ authorize\ the\ above\ doctor\ and/or\ any\ provider\ or\ supplier\ of\ services\ in\ this\ office\ to\ release\ the\ information\ required\ to\ secure\ the\ payment\ of\ benefits.\ I$ authorize the use of this signature on all insurance submissions.

Signature of Responsible Party Date