

# 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.

**F** \_\_\_\_\_ **X** \_\_\_\_\_ **X**  
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 due 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 my dental 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.

**F** \_\_\_\_\_ **X** \_\_\_\_\_ **X**  
Today's Date Signature of Subscriber  
\_\_\_\_\_  
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.***