

The Teeth Boutique PLLC
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(E): TheTeethBoutique1933@Gmail.Com

“Signature on File” Authorization
Statement to Permit Payment of Any Health Insurance

Name of Insured: _____

Name of Patient: _____

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this or any subsequent office visit(s). I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim.

I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured’s health carrier must be paid for at the time of services.

I hereby authorize payment directly to The Teeth Boutique for any services rendered to me by The Teeth Boutique or any of his authorized agents.

I authorize the release of all medical information to the insured’s health insurance carrier that is:

- 1) Acquired in the course of my examination or treatment
- 2) Which may have a bearing on the benefits payable under this or any other plan that provides benefits or services.

I authorize The Teeth Boutique or any of his authorized agents to assist me in obtaining payment from my dental insurance policy(ies)

I authorize a copy of this “Signature on File” form to be used in place of the original and that this copy may be used on all my claim submissions.

AUTHORIZED PERSON’S SIGNATURE

DATE