NORTHPARK DENTAL

AUTHORIZATION FOR INSURANCE CLAIM

If this office accepts insurance, I understand that I am responsible for payment of all services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Northpark Dental of the group insurance benefits otherwise payable to me.

I understand that I am responsible for all costs of dental treatment. I understand that the co-payment estimates by Northpark Dental are provided as courtesy and the actual payments from my insurance company maybe different from these estimate quotes. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

{Please Print Name}

_____

{Signature}

_____

{Date}