YOUR EXPRESSIONS FAMILY DENTISTRY

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AUTHORIZED SIGNATURE ON FILE

Release of Information/Financial Responsibility/Authorization for Payment

I (name of the patient)_____and/or(name of insured)_____ hereby authorize Your Expressions 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 (name of employer)_____. I hereby authorize payment of dental benefits otherwise payable to me directly to the office above. I have reviewed the payment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits 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.

Signature of Patient(parent or guardian of minor)_____
Signature of Insured:_____ Today's date:_____
This "Authorization " will be valid from this date and shall expire in one year.
Expiration Date: _____