# Authorization for Signature on File

## Release of Information/ Financial Responsibility/ Authorization for Payment

I (name of patient)________________________________________ and/or (name of insured) ____________________________________ hereby authorize **Sterling Dentistry** 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 herby authorize payment of dental benefits otherwise payable to me directly to the office above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit 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 if minor) :__________________________________________________

Signature of Insured:______________________________________________________________ Today's Date:______________________

This "Authorization" will be valid from this date and shall expire in one year. Expiration Date:_______________________

A photocopy of this document may act as an original.