DRS OF SMILES

Scott T. LeSueur DDS
Charles A. Dodaro DDS
Glenn T. LeSueur DDS

Authorization for Signature on File

Release of Information/Financial Responsibility/Authorization for Payment

I, _____ and/or _____ hereby authorize the office of Drs of Smiles to affix my name to any and all claims or documents as related to any and all dental benefits due me and my dependents through my employment with _____. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed 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.

This "Authorization" will be valid from the date and shall expire in one year.

A photocopy of this document may act as an original.

This authorization is in no way a guarantee of payment of the set treatment plan from your insurance company.

_____ Signature of Insured

_____ Witness

_____ Signature of Patient (parent/guardian if minor)

_____ Today's Date

_____ Expiration Date