INSURED

Authorization for Signature on File

Authorization of Payment

I hereby authorize the office of **Potach & Mitchell DDS, PA** to affix my name to any and all claims or documents as related to any health benefits due me and my dependents through my employment with ________________________________.

I hereby authorize the payment of dental benefits otherwise payable to me, directly to the office of **Potach & Mitchell DDS, PA.**

This "Signature On File" will be valid from this date and shall expire in one year.
A photocopy of this document may act as an original.

Today's Date	Signature of Insured
Expiration Date	Witnessed By

PATIENT

Authorization for Signature on File

Release of Information / Financial Responsibility

I hereby authorize the office of **Potach & Mitchell DDS, PA** to affix my name to any and all claims or documents as related to any and all health benefits due me.
I have reviewed the following 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 this claim.

This "Signature On File" will be valid from this date and shall expire in one year.
A photocopy of this document may act as an original.

Today's Date	Signature of Patient
Expiration Date	Witnessed By