Goldberg Implants & Periodontics

David A. Goldberg, D.M.D
Diplomate, American Board of Periodontology
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Authorization for Signature on File

Release of Information/Financial Responsibility/Authorization for Payment

I _____, and/or _____
Name of Patient (Parent/Guardian of Minor) (Name of Insured)

hereby authorize the office of Goldberg Implants and Periodontics to affix my name to any and all claims or documents as related to any and all health/medical/dental benefits due to me and my dependents through my insurance. This includes all correspondence regarding health/medical//dental records with my other treating doctors.

I will review all treatment plans and fees. I agree to be responsible for all charges for dental services and materials since my dentist does not have 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 these claims.

A photocopy of this document may act as an original.

_____

Signature of Patient Today's Date

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