

**SIGNATURE ON FILE
ONLY IF YOU HAVE INSURANCE**

WE DO NOT BILL SECONDARY INSURANCES

So you don't have to sign an insurance form at each dental visit, we will maintain this "signature on file " for you.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Provider, insurer or other Organization to release any information regarding the dental history, treatment or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

Signature of Subscriber (patient/parent of minor)

Date

AUTHORIZATION TO PAY BENEFITS TO BELOW NAMED DENTIST: I hereby authorize payment to be paid directly to **Taurance N. Bishop DDS**

Signature of Subscriber (patient/parent of minor)

Date

We will reserve a space for you and/or your family members. This time is allotted especially for you and/or your family member. Please advise the Doctor's office within 48 hours if for whatever reasons you and/or your family members cannot keep the scheduled appointment. If we do not receive a call within 48 hours, you will be responsible for a \$25.00 fee for each missed appointment. If a third appointment is missed by you and/or a family member that was not properly cancelled, we are sorry to say that we will have to dismiss you as a patient.

Your payment or your co-payment (if you have insurance) is expected at time of treatment.

I have read and understand all of the above information.

Signature of Subscriber/patient/parent of minor

Date