Dr. Donna Williams, D.D.S F.I.N.D

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SIGNATURE ON FILE

Please initial on the line that applies to you:

_____ I authorize use of this form on all my insurance submissions.

_____ I authorize release of information to all my insurance carriers.

_____ I understand that I am responsible for my bill.

_____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.

_____ I authorize payment directly to my doctor.

_____ I permit a copy of this authorization to be used in place of the original.

DATE: _____

NAME: _____

SIGNATURE: _____