Authorization for Signature on File Form

Patient's Name_____

Last First MI D.O.B

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the office of ***Nicholas Cain, DDS at Healthy Smiles of Northwest Indiana***.

The "Signature on File" will be valid from this date and shall not expire. A photocopy of this document may act as an original. I know I have a right to receive a copy of this authorization upon request. My signature also applies to any dependents listed under my policy. I agree to be responsible for all charges for dental services and materials not paid by my dental plan, unless prohibited by law or the treating dentist, our practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information in connection to my claims.

_____` _____

Patient Signature (or Parent/Guardian) Date