AUTHORIZATION FOR SIGNATURE ON FILE
AUTHORIZATION OF PAYMENT AND RELEASE OF INFORMATION
AGREEMENT OF FINANCIAL RESPONSIBILITY

I___________________________________, understand and agree that I am responsible for all charges incurred for services provided by Easton Smiles, office of Dr. Thomas Herlihy, regardless of insurance coverage for myself and dependent family members. I understand that all pre-estimates are not a guarantee of coverage and are subject to the policy benefits at time of processing. I agree that any balance not paid by my insurance company within sixty (60) days of treatment will be my full financial responsibility to pay. I agree to furnish the insurance company and/or Easton Smiles with any additional information requested to expedite the payment of my claims. I hereby authorize the release of any information related to all claims for benefits on behalf of myself and/or family dependents. I hereby assign and authorize payment of dental benefits, otherwise payable to me, directly to Easton Smiles. I agree that a photocopy of this document and my authorization may act as the original and that my signature below shall authorize payment to the dentist for any services rendered to me or my dependents as if I had signed each benefit assignment of future claims.

I hereby authorize payment of dental benefits otherwise payable to me, directly to Dr. Thomas Herlihy. This signature will remain on file within the patient records.

Printed Name and Address: ____

Signature: ____

Date: ____