RIVERSIDE DENTAL, P.C.

[redacted]

I have received a copy of this office's *Notice of Privacy Practices.*

SIGNED:_____ **DATE:**_____

[redacted]

(Authorization of payment)

I hereby authorize the payment of dental benefits otherwise payable to me, directly to the office of **RIVERSIDE DENTAL, P.C.**

SIGNED:_____ **DATE:**_____

[redacted]

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I also authorize release of any information relating to the billing and processing of any insurance claim.

SIGNED:_____ **DATE:**_____