Kantakevich, Doring, & Perez-West, P.A.

Joseph J. Kantakevich, D.D.S.
Charles A. Doring, D.D.S., F.A.G.D.
Clemetina Perez-West, D.D

Authorization for Release of Information

I hereby authorize this dentist to apply for benefits on my behalf for covered services rendered.

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical or dental information for this or any related claim, to my insurance carrier. A copy of the authorization may be used in place of the original.

Either my insurance carrier or I may revoke this authorization at any time in writing.

______________________________ ______________
Signature of patient, insured, or beneficiary Date

Assignment of Benefits

I hereby authorize payment of all dental insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this dentist for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original.

______________________________ ______________
Signature of patient, insured, or beneficiary Date

A Financial Agreement

I hereby assume financial responsibility for and agree to make payment in full to "**Katakevich, Doring, & Perez-West, P.A.**" for all charges for services or dental supplies furnished the above named not otherwise authorized or paid by my insurance carrier. Payment is to be made within 30 days as statements are presented with settlement in full, or payment arrangements to be made with the business office. I certify that the financial information given is true, accurate, and complete to the best of my knowledge, and further authorize to "**Katakevich, Doring, & Perez-West, P.A.**" to investigate any and all financial information concerning this or related claims.

______________________________ ______________
Signature of patient, insured, or beneficiary Date