Patient Name ____
(Please Print)

A. SCOTT CROSS, D.D.S.

2718 N. Highland Ave. — Jackson, TN 38305
Telephone: (901) 668-8344

SIGNATURE ON FILE

- ☐ I authorize use of this form on **all** my insurance submissions.
- ☐ I authorize release of information to all my **Insurance Companies.**
- ☐ 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 Companies.
- ☐ I authorize payment directly to my doctor.
- ☐ I permit a copy of this authorization to be used in place of the original.
- ☐ My signature also applies to the dependents listed on the back of this card.

Signature ________________________________ Date ________________