MICHAEL FERNANDEZ

FAMILY DENTISTRY

a Division of Atlantic Dental Care, PLC

PATIENT AUTHORIZATION

I certify that the information provided on my patient information sheet is true and correct to the best of my knowledge.

I hereby authorize payment directly to Michael E. Fernandez D.D.S. of all insurance benefits otherwise payable to me for the services rendered. I confirm that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I assume responsibility for any collection, attorney fees and court cost incurred in the collection of this account.

I authorize the above noted doctor to release any information required to secure the payment of insurance benefits. I authorize the use of this signature on all insurance submissions.

For scheduling and account purposes only, please list below any family members we may discuss your chart/account information with?

*****Please list names and relationship below *****

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

_____

Printed Name of Patient, Parent, or Guardian Responsible for Account

_____ _____

Signature Date