Authorization for Signature on File

Release of Information/Financial Responsibility/Authorization for Payment

I hereby authorize payment directly to Link Dental Care for all insurance benefits otherwise payable to me for dental services rendered. **I understand I am financially responsible for all charges, whether or not paid by insurance, for any and all dental services rendered on my behalf or my dependents.** I authorize Link Dental Care to release all information necessary to secure the payment of benefits and to use my signature below for all insurance submissions.

Print:_____

Signature of Patient/Responsible Party:_____

Date:_____