Insurance Authorization Form

Please read and sign this statement so we can notify your insurance company that we have permission to accept assignment (payment) directly from them, on your behalf, for services we render.

I hereby authorize my insurance company to make payment directly to Arlington Dental Group, P.C. for dental service provided.

I understand that payment is required at the time of treatment for the estimated non-covered portion of the dental fee.

I further understand that the insurance companies will not guarantee the accuracy of the estimates of benefits due me before treatment is rendered. I therefore understand that the Arlington Dental Group, P.C. cannot be held responsible if the estimate of coverage made at the time of treatment is different from the actual coverage. Upon payment by the insurance company, if there is a balance due, I understand that the balance must be paid. If payment received results in a credit balance, a refund check will be issued.

Signature of policyholder: _____

Please print name of policyholder: _____

Signature of Account Guarantor: _____
(If different from policyholder)

Please print name of Account Guarantor: _____

Date: _____