

Signature on File Form

In order to facilitate a speedy check out, Alaska Center for Dentistry will maintain this "signature on file" for you. Please select one or both of the following.

CONTINUOUS AUTHORIZATION

I authorize Alaska Center for Dentistry to keep my signature on file and to charge my credit card account listed below for treatment performed in this office on any given date of service. I understand that this authorization will remain in effect for a period of 24 months, unless I cancel this authorization in writing. I also understand that this form is kept in the strictness of confidentiality.

AUTHORIZATION FOR UNPAID CLAIMS

I authorize Alaska Center for Dentistry to charge my credit card account listed below for the balance of charges not paid by insurance within 45 days that does not exceed the charges of the claim in question. I understand that this authorization will remain in effect for a period of 24 months, unless I cancel this authorization in writing. I also understand that this form is kept in the strictness of confidentiality.

In order for us to accept your insurance as payment, please complete the following.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

X _____ Date _____
Signed (patient, parent or legal guardian if minor)

AUTHORIZATION TO PAY BENEFITS TO NAMED DENTIST: I hereby authorize payment directly to Alaska Center for Dentistry for services rendered.

X _____ Date _____
Signed (subscriber, patient, parent or legal guardian if minor)

CREDIT CARD

(Circle one) Visa MasterCard Discover American Express HealthCare Creditline

Bank name: _____ Card Type: Credit or Check

Account Number: _____ Exp. Date _____

Printed Name: _____

Cardholder Signature: _____