

Insurance Authorization
Palmetto Smile Center

I authorize Dr. James and the staff of Family Dentistry of Newberry to release any information including the diagnosis and records of any treatment or examination rendered to me or to my child during the period of such dental care to third party payers and/or health practitioners.

I authorize and request, my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, or on the behalf of my dependents.

Family Dentistry of Newberry will file all insurance claims on my behalf or on the behalf of my dependents. I understand that my dental insurance carrier should pay on dental claims within 45 days. After such time period, it becomes my responsibility to contact my insurance carrier and provide payment for services rendered.

I have read and understand all paragraphs on this page.

Signature: _____
(If minor, signature of parent or guardian required)

Date: _____