AUTHORIZATION FOR SIGNATURE ON FILE
AUTHORIZATION OF PAYMENT/RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

I _____, understand and agree that I am responsible for all charges incurred regardless of insurance coverage. I understand that Anthony A. Ly, D.D.S., has accepted the insurance company's verification of coverage and benefits in good faith that the claim will actually be covered as described by the insurance company. In the event that the insurance company does not cover the claim for the verified benefits, I agree to be responsible for all charges for dental services and materials which I and/or my dependants have incurred and authorized in my and/or my dependants treatment. I agree that any balance not paid by my insurance company within sixty days will be my responsibility to pay. I agree to furnish the insurance company and Dr. Ly with any additional information or paperwork requested to expedite payment of my claim. To the extent permitted under applicable law, I hereby authorize release of any information relating to all claim for benefits submitted on behalf of myself and/or my dependants. I hereby assign and authorize payment of dental benefits otherwise payable to me, directly to the office of Anthony A. Ly, D.D.S. I agree that a photocopy of this document and authorization may act as an original and that my signature below shall authorize payment to the dentist for any services rendered to me or my dependants as if I had signed each benefit assignment of future claims.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Anthony A. Ly, D.D.S.
This "Signature on file" will be valid from this date and shall expire in one year.
A photocopy of this document may act as an original.

_____ _____

TODAY'S DATE SIGNATURE OF INSURED