



277 West End Avenue, Suite 1B
New York, NY 10023
(212) 877-7177
(212) 873-8633

Signature on File

Name of Insured: Last _____ First _____

Name of Patient: Last _____ First _____
(If other than insured)

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this office visit. I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim.

I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured's insurance carrier must be paid for at the time of services.

I hereby authorize payment directly to Dr. Alan D. Frankel D.M.D., P.C., for any services rendered to me by Dr. Alan D. Frankel D.M.D., P.C.

I authorize the release of all dental information to the insured's insurance company that is 1.) Acquired in the course of my examination or treatment and 2.) which may have a bearing on the benefits payable under this or any other plan that provides benefits or services.

I authorize Dr. Alan D. Frankel D.M.D., P.C, or any of his authorized agents to assist me in obtaining payment from my dental insurance company.

I authorize a copy of this "signature on file" form to be used in place of the original and that this copy may be used on all my insurance submissions.

Insured's or Authorized Person's Signature

Date