AUTHORIZATION FOR SIGNATURE ON FILE

Release of Information / Financial Responsibility / Authorization of Payment

---

I hereby authorize OrthoGrace Dental to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents.

I hereby authorize payment of dental benefits otherwise payable to me directly to the office above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim.

Signature of Patient (parent or guardian of minor):_____

Signature of Insured:_____ Today's Date:_____

This Authorization will be valid from this date and shall expire in one year.