Dr. Terry F. Rakowsky

FAMILY & COSMETIC DENTISTRY

RELEASE OF INFORMATION

I authorize the release of any information necessary to process my insurance claim(s). I agree that this authorization will cover all dental services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

Signed (Patient or Representative) _____
Date_____

INSURANCE PAYMENT POLICY

I will be responsible for paying my annual deductible, co-payment at each visit, any charges for non-covered services, and charges for services exceeding my annual maximum.

Signed (Patient or Representative) _____
Date _____

ASSIGNMENT OF BENEFITS

I authorize and request payment of dental benefits directly to my dentist.

Signed (Patient or Representative) _____
Date _____

PLEASE NOTE:

If you need to cancel an appointment, we request that you give us at least 24 hours notice. We reserve the right to charge you for a missed appointment if we are not notified.