Scott D. Allman, D.D.S., P.C.
Restorative and General Dentistry

FOR INSURANCE PROCESSING

SIGNATURE ON FILE

****AGREEMENT TO PAY: The undersigned accepts the fee charges as a lawful debt and promises to pay said fee including the costs of collection, attorney fees and court costs if such be necessary.**

I authorize release of information to all insurance companies and permit this copy of my signature to be kept on file for processing dental insurance claims for me and my dependants. I authorize payment to go directly to my dentist. I understand that all responsibility for payment for dental services provided in this office for myself or my dependants is mine. I also understand this dental office has no contract or connection with my dental insurance company. I agree to pay my deductible and any portion of the dental fee not covered by my dental insurance plan at the time of service. I will notify this office if I have a change in my dental coverage.

Subscriber/Guarantor: ______________________________ **Date:** ___________