Galstan &Ward Family Dentistry

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SIGNATURE RELEASE FORM

I hereby authorize this dental office, owned and operated by Samuel W. Galstan, D.D.S, M.P.H, M.A.G.D and C. Sharone Ward, D.D.S., to affix my name, or my financially responsible party's name on any dental form on behalf of my benefit, or any members of my family's benefit(or anyone for whom I am the financially responsible party of or for) to secure reimbursement for as long as I am a patient of this dental practice (or as long as I have a balance due that may be covered by my insurance carrier or self-funded plan). I hereby authorize this practice to furnish information to insurance carriers or self-funded plans concerning my treatment, and I hereby assign all benefits directly to Dr. Galstan. I am ultimately the financially responsible party for this account, and regardless of insurance compensation, coverage, reimbursement, or estimated benefit, agree to pay the balance of my account with Dr. Galstan's office (and the account(s) of persons for whom I am also the financially responsible party) in full. Returned checks and balances older then 30 days may be subject to additional collection fees and billing charges of 1.5% per month. Should collection have to be taken against your account, you are responsible for all fees and costs incurred therein, including collection fees and attorney's fees of 33 1/3%. This office reserved the right to charge up to $50 for broken or missed appointments, or up to $25 for appointments cancelled with less then 24 hours notice.

Signed:_____ Date:_____

(Insured covered employee/financially responsible party)

Social Security Number of Financially Responsible party: ____-____-____

Date of Birth of Financially Responsible party: ____/____/____

Place of Employment of covered employee: _____

Address of place of employment: _____

Name of Dental Insurance Carrier: _____

Other Covered Family Members:

Name/Signature _____ SSN: _____

Name/Signature _____ SSN: _____

Name/Signature _____ SSN: _____

Name/Signature _____ SSN: _____