



Additional Authorizations Form

Authorization for Insurance Payment

I, _____, authorize Dr. April Patterson and her office the release of any medical/dental information necessary to process insurance claims. I also authorized the release of any medical information necessary to complete a referral to a specialist, if needed.

Client Signature: _____ **Date:** _____

I authorize payment of dental insurance benefits to Dr. Patty's Dental Boutique for services provided as described on my related claims. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not they are paid by the insurance carrier. I acknowledge receipt of a treatment plan and price before receiving any treatment.

Client Signature: _____ **Date:** _____

Photography Release/Authorization

I, _____, hereby grant permission to Dr. Patty's Dental Boutique to take and use photographs and/ or digital images of me for use in educational materials and or news/ media releases. These materials might include printed or electronic publications, web sites or other electronic communications. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s).

I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions shall be the property of Dr. Patty's Dental Boutique.

Client Signature: _____ **Date:** _____