All About Smiles,PC
Dr. Dave Motz, DDS

Authorization to Release and Assign Insurance Benefits

I authorize release of any information required to act on this claim and permit a photographic, electronic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Dr. Motz the dental/medical benefits from my insurance company, which I am entitled to, for all services rendered. I understand I am responsible for any unpaid balance on my account.

Signature: _____

Date: _____

Annual update, please initial and date:

Date	Initial

Date	Initial

Date	Initial

Failed Appointment Policy

1) Appointments that are missed will result in a $25.00 or $50.00 charge based on the length of the scheduled appointment.
2) If an appointment needs to be rescheduled, please notify us no later than 24 hours in advance, to avoid this charge.

I understand and have been informed of the Failed Appointment Policy.

Signature: _____
Date: _____