Cross Keys Dental
Voorhees Dental Smiles

Authorization for Payment of Dental Services (Signature on File)

I hereby authorize and direct payment of the dental benefits payable to me, directly to Cross Keys Dental / Voorhees Dental Smiles.

X_____
Subscriber Signature Date

Balances not paid by insurance because it is the patient's co-insurance or because the procedure is not a covered benefit, changes to insurance coverage, or for any other reason will be the sole responsibility of the patient. The patient will be billed for any outstanding amount as soon as the "Explanation of Benefits" is received from the insurance company.

X_____
Subscriber Signature Date

Any unpaid balance must be paid in full before any new service can be provided. Any outstanding balance will accrue interest at the rate of 1.5% per month and if account becomes delinquent past three months, any and all legal and or collection fees will be added to an outstanding balance.

X_____
Subscriber Signature Date