Beth Weinstein, D.D.S., P.C.
180 East Pulaski Road
Huntington Station, NY 11746
631 622-5000

Authorization form

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that I am responsible for collection or legal fees should collection agencies need to be used or legal action taken to gain payment. I understand that I am responsible for finance charges after 30 days of non-payment.

Signature ____________________________________ Date__________________________

Name (printed)____________________________________