INSURANCE AUTHORIZATION – SIGNATURE ON FILE

Sequatchie Valley Dental Associates, PC
507 BETSY PACK DRIVE SUITE B JASPER, TN 37347 423-942-5508

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents.

I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor as listed above. I agree to be held responsible for all charges and services not paid by my insurance company.

Today's Date Signature of Patient or Insured

Witnessed By

A photocopy of this authorization may act as an original.