LINDSBORG FAMILY DENTAL CARE

Erik J. Peterson, DDS | 101 N. Harrison, PO Box 311 • Lindsborg, KS 67456-2204 (785)227-2299

SIGNATURE ON FILE

for Patients with Insurance Coverage

Patient Name:

______________________ ______________________ ____
Last First MI

____
Preferred Name

In order for Lindsborg Family Dental Care to file insurance claims on behalf of the patient, the following information must be completed. Refusal to grant all the following authorizations, and provide a signature, means that the patient, parent or guardian is responsible for the entire balance on the date of service.

If the patient is under 18 years of age, a parent or guardian must complete this information.

☐ ***I authorize Dr. Erik Peterson, and/or the staff of Lindsborg Family Dental Care, to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.**

☐ ***I authorize release of any information related to any claims to all my insurance companies or other relevant parties.**

☐ ***I authorize Dr. Erik Peterson, and/or the staff of Lindsborg Family Dental Care, to act as my agent in helping me obtain payment from my insurance companies.**

☐ ***I authorize payment of health and dental benefits otherwise payable to me, directly to Dr. Erik Peterson, and/or Lindsborg Family Dental Care.**

☐ ***I understand that it is my responsibility to know and understand my insurance plan and the covered benefits.**

☐ ***I understand that any information about my insurance coverage given to me by Dr. Erik Peterson, or the staff at Lindsborg Family Dental Care, is based on limited knowledge of my specific plan, and DOES NOT guarantee coverage.**

☐ ***I understand that I am responsible for my bill and I agree to pay all charges for services and items provided to me. I am prepared, if for any reason my insurance companies refuse payment in part or full, to pay the remaining balance.**

☐ ***I understand that if I am not satisfied with the payment, or lack of payment, from my insurance company, it is my responsibility to contact them and resolve any issues.**

☐ ***I permit a copy, or electronic documentation, of this authorization to be used in place of the original.**

☐ ***This "Signature on File" is valid for one year from the date indicated below.**

What is the relationship to the patient of the individual completing this information? *

◯ Self ◯ Parent ◯ Legal Guardian

If not the patient, name of individual completing the information:

____

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The signature of the patient (if over 18 years of age), parent or legal guardian is required.

Signature ____ ____________

Date ____

Response Date: ____________