

**Vienna Dental Center,
Bart L. James, D.D.S., Roger L. Clouse, D.D.S., Ltd.**

Insurance Authorization and Financial Policy

I authorize my dental insurance company(s) to pay Vienna Dental Center all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Vienna Dental Center to release all information necessary to secure the payment of benefits.

I understand payment is expected at the time services are rendered, unless other arrangements have been made. This includes any co-payments or deductibles (amount not covered by your insurance).

Accepted payments include cash, checks, American Express, Discover, MasterCard & Visa.

Name (Please Print)

Patient/Parent Signature

Date