SIGNATURE ON FILE

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize

_____, to pay and hereby assign directly to William E. Paul, D.D.S., P.C. all medical and dental benefits, if any, otherwise payable to me for services as described on the attached forms. I understand I am financially responsible for all charges incurred less any dental insurance benefits when received by and paid to William E. Paul, D.D.S., P.C.

Authorization is hereby given to release all information necessary to the payment of said benefits.

Authorized Signature of Covered Person/Employee:

X_____ Date_____

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