

Dr. Ericka Klein
227 Lancaster Avenue Suite 201
Devon PA 19333
610-688-4100

Insurance Authorization
Signature on File

I authorize my health care provider to affix my name to all insurance submissions, documents, and all information requested from my insurance companies relating to any and all health benefits due to me and my dependents. I allow release of all my dental records to other dental associates and dental and medical specialists as needed, for completeness regarding my dental care. I also allow for photographs to be taken of my mouth and dental work for the use of education and as a record of progress of my treatment.

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

My signature to this document is valid from this date until notified by me or expires in five years. A photocopy of the authorization may act as an original.

TODAY'S DATE

SIGNATURE OF PATIENT OR INSURED

EXPIRATION DATE

WITNESSED BY