Joel F. Bookout, DDS, PC
4141 Ringgold Road
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Chattanooga, TN 37412

# AUTHORIZATION FOR SIGNATURE ON FILE

Release of Information/Financial Responsibility

I _____ herby authorize the office of Joel F. Bookout DDS to affix my name to any and all claims or documents as related to any and all health benefits due to me.
I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. Also, I assign payment to go directly to Joel F. Bookout, DDS.

This "Signature on File" will be valid from this date. A photocopy of this document may act as an original.

_____ _____

Today's Date Signature on Patient or Parent