PATIENT

Authorization for Signature on File

Release of Information / Financial Responsibility

I _____ hereby authorize the office of Donna L. Kiesel, DDS., to affix my name to any and all health benefits due 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.

This "Signature on File" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

_____ _____

Today's Date Signature of Patient

_____ _____

Expiration Date Witnessed By