



ALTSCHULER
PERIODONTIC and IMPLANT
CENTER

Lifetime Signature Authorization/Financial Responsibility Statement

Because I am requesting dental treatment for myself and/or a minor child, I accept complete financial responsibility for payment of all fees and services rendered.

I understand that insurance claim filings on my behalf are being done as a courtesy. If my insurance carrier fails to make payment within 90 days, I understand that I am responsible for any remaining balance.

I authorize the release of any medical/dental information necessary to process my insurance claims.

Signature _____ Date _____

I authorize payment of medical/dental benefits to Dr. Altschuler's office for services rendered to me.

Signature _____ Date _____

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