

New Town Dental ArtsSM

SEBASTIANA SPRINGMANN, DDS

Pre-Authorized Health Care Form

I authorize **NEW TOWN DENTAL ARTS** to keep my signature on file and to charge my _____ account for:

_____ Balance of charges not paid by insurance within 45 days and not to exceed \$ _____

For:

_____ This visit only

_____ All visits this year

_____ Recurring charges (ongoing treatments) of \$ _____

Every _____
(frequency)

From _____ to _____
(date) (date)

I assign my insured benefits to provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health provider.

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____

State: _____ Zip: _____

Card of choice: MC _____ VISA _____ CARE _____

Account Number: _____

Expiration Date: _____

Cardholder Signature: _____

Date: _____