Elite Dentistry of Rhode Island

1351 South County Trail, Building 2 #205
East Greenwich, RI 02818-5080
Phone: 401-885-6460
Fax: 401-885-3933

Date: ______________

SIGNATURE ON FILE

The undersigned here by authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature authorizes my dentist to submit claims for benefits for services rendered or to be rendered without my signature on every claim submitted for my dependants.

Authorized signature of covered person (For minor, Parent or Guardian)

Date: ______________

The undersigned authorizes payment directly to **Elite Dentistry of Rhode Island** otherwise payable to him/her

Authorized signature of covered person (For minor, Parent or Guardian)

Date: ______________

Our office has a strict policy where a $50 fee will be charged for broken appointments unless 24 hrs advance notice is given so that we may reschedule you or reserve that time for another patient

Authorized signature of covered person (For minor, Parent or Guardian)

Date: ______________