277 West End Avenue, Suite 1B

(212) 877-7177

(212) 873-8633

Signature on File

Name of Insured: Last_____ First_____

Name of Patient: Last_____ First_____

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this office visit. I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim.

I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured's insurance carrier must be paid for at the time of services.

I herby authorize payment directly to Dr. Jennifer S. Stachel D.M.D., P.C., for any services rendered to me by Dr. Jennifer S. Stachel D.M.D., P.C.

I authorize the release of all dental information to the insured's insurance company that is 1.) acquired in the course of my examination or treatment and 2.) which may have a bearing on the benefits payable under this or any other plan that provides benefits or services.

I authorize Dr. Jennifer S. Stachel D.M.D., P.C., or any of his authorized agents to assist me in obtaining payment from my dental insurance company.

I authorize a copy of this "signature on file" form to be used in place of the original and that this copy my be used on all my insurance submissions.

_____ _____

_____ _____

Insured's or Authorized Person's Signature Date