Mario R. Gebbia, D.M.D., P.A.

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SIGNATURE ON FILE

✓ I authorize the use of this form on **all** my insurance submissions.

✓ I authorize release of information to **all** my insurance companies.

✓ **I understand that I am responsible for my bill.**

✓ I authorize Dr. Mario R. Gebbia to act as my agent in helping me to obtain payment from my insurance company or companies.

__ I authorize payment directly to Dr. Mario R. Gebbia, D.M.D.

✓ I permit a copy of this authorization to be used in place of the original.

PRINT NAME_____

SIGNATURE_____DATE_____

PLEASE REVIEW OUR INSURANCE POLICY

We contracted with only certain insurance companies. We will accept other insurances as long as they allow for benefit assignment to a non-participating dentist. As a non-participating dentist we are not contractually obligated to accept your insurance carrier's payment as full compensation. You are responsible for any payment over and above the fees and percentages provided by your insurance carrier.