

**Signature on File/DMFS Acknowledgment**  
**Release of Information/Financial Responsibility/Authorization for Payment**

I hereby authorize the office of Dean Furkioti D.D.S. to affix my name to any and all claims or documents as related to any and all health benefits due to me. I authorize the release of any medical information necessary to process claims. I also authorize payment of dental benefits, otherwise payable to me, directly to the office listed above.

The office will submit charges to the insurance carrier as a courtesy to the patient. Any charges that have not been paid within 90 days of treatment from the third party carrier will be the patient's full responsibility. I further understand that a 1.0% finance charge (12% annually) will be added to any balance over 90 days old. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I will make any corresponding copayment(s) at the time of service.

Additionally, I acknowledge receipt of the Dental Materials Fact Sheet dated October 2001.

Attention parents of minors: I authorize the office to take routine x-ray on my child as deemed necessary:  YES  NO

\_\_\_\_\_  
Name of patient (PLEASE PRINT)

\_\_\_\_\_  
SIGNED (Patient, or Parent if Minor)      Date

\_\_\_\_\_  
SIGNED (EMPLOYEE/INSURED)      DATE

A photocopy of this document may act as an original