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SIGNATURE ON FILE

- I authorize 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 my doctor to act as **my** agent in helping me obtain payment from my Insurance Companies.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Name (Please Print) _____ Medicare # _____
(if applicable)

Signature _____ Date _____