



**INSURED**  
**Authorization for Signature on File**  
Authorization of Payment

I \_\_\_\_\_ hereby authorize the office of Eric W. Lerner, DDS, to  
(name of insured)  
affix my name to any and all claims or documents as related to any and all health benefits due me  
and my dependents through my employment with \_\_\_\_\_  
(name of employer)

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Eric W. Lerner, DDS. This "Signature on File" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

_____ Signature of Insured	_____ Expiration Date
_____ Witnessed By	_____ Today's Date



**PATIENT**  
**Authorization for Signature on File**  
Release of Information / Financial Responsibility

I (name of patient) hereby authorize the office of Eric W. Lerner, DDS, to affix my name to any and all claims or documents as related to any and all health benefits due me. I have reviewed the following treatment plan and fees. 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. To the extent permitted under applicable law, I authorize release of any information relating to this claim. This "Signature on File" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

_____ Signature of Insured	_____ Expiration Date
_____ Witnessed By	_____ Today's Date