PORTER, MARTIN, SALMAN, PA

PATIENT _____

I authorize the release of any medical and/or dental information or other information necessary to process the patient's claim. I understand that I am responsible for all costs of medical/dental treatment. I also understand that my records may be transported to another Porter, Martin, Salman, P.A. location.

_____

Signature (Patient or parent/guardian if minor) Date

I hereby authorize payment of the dental and/or medical benefits otherwise payable to me directly to the above named dental entity.

_____

Signature (Insured person) Date

I agree, in order for us to service your account or to collect monies you may owe, Porter, Martin, P.A. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages, text messages and/or use of automatic dialing devices, as applicable.

I/we have read this disclosure and agree that Porter, Martin, P.A., its employees and/or agents may contact me/us as described above.

_____

Signature Date