

**Carlee A. Reiler, D.D.S., P.C.
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It is standard courtesy for this office to file all insurance claims on behalf of the patient. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my child during the period of such dental care to third party payors and/or health/dental practitioners.

I understand that my dental insurance carrier may pay less than the actual bill for services. Although your employer carries a contract with the insurance company, this does not constitute as guarantee of payment and Dr. Reiler is not a party to that contract. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Payment may be made by cash, check or debit/credit card. Financing is available through CareCredit, which offers zero interest payment plans. A financial arrangement may be made for your treatment and documented in your chart.

X

SIGNATURE OF PATIENT OR GUARDIAN

RELEASE AUTHORIZATION