INSURANCE AUTHORIZATON

Duneland Dental
Dr. Christine A. Faron
106 Indian Boundary Road
Chesterton, IN 46304
219-926-7595

SIGNATURE ON FILE

☐ I authorize use of this form on all my insurance submission.
☐ I authorize release of information to all my insurance carriers.
☐ I understand that I am responsible for my bill.
☐ I authorize payment directly to my doctor.
☐ I permit a copy of this authorization to be used in place of the original.
☐ I understand that there may be an additional charge to my account after the second submission of my claims. This will be applied for the following reasons: if your insurance requests repeated copies of x-rays and or narrative reports. However, you will be notified of the situation before any charges are applied, so that you may contact your insurance company in regards to the issue.

Name____
Please Print Patient Name

Signature_________________________________ Date__________________________
Patient or Parent/Guardian If Minor