Michael R. Fontana D.M.D
General Dentistry

Acknowledgement of Financial Policy

I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility and due at the time of service.

I authorize my insurance benefits be paid directly to Dr. Michael R. Fontana.

I authorize Dr. Michael R. Fontana to release pertinent dental information to my insurance company when requested, or to facilitate payment of a claim.

I have read, understand and agree to the above Financial Policy.

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Date	**Signature**	**Printed Name**

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