Angela Pourghassemi, DMD
2305 Camino Ramon Suite 230
San Ramon, California 94583

Authorization and Release

I understand that payment is due in full at time of treatment unless prior arrangements have been approved. I understand that I am responsible for payment of services rendered at the time of treatment and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorized payment directly to the dental office of Dr. Angela Pourghassemi from my dental insurance group, otherwise payable to me. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____

Signature Date