INSURANCE AUTHORIZATION- SIGNATURE ON FILE

DONALD J. SABOURIN, DDS
Joel Hayden, DDS
3456 SHATTUCK RD.
SAGINAW, MI 48603
(989)792-8315

I hereby authorize my dental health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all benefits due to me.

I also authorize payment of benefits otherwise payable to me, directly to my doctor listed above. I agree to be held responsible for all charges and services not paid by my insurance company.

I authorize permission to my doctor listed above to complain to the insurance commissioner for any reason on my behalf.

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Signature of Patient/Parent