LIFE DENTAL SPECIALTIES
Periodontics and Dental Implants

Anthony T. Quinta, D.M.D., LLC
Diplomate of the American Board of Periodontology

ACCOUNT AUTHORIZATION

Dear Patient:

Our current office policy requires that only the authorized patient, namely yourself, or the individual(s) who has/have been authorized by you, to inquire as to the details of your account and/or make changes to your account. Dr. Anthony Quinta and staff take these procedures very seriously, as they are intended to safeguard both your private information, as well as your personal account details. We will allow only the Authorized Individual indicated on this Account Authorization form access to your account. You may name up to two (2) Authorized Individuals. Dr. Quinta and staff are not liable for and may not be held responsible for any authorized actions taken with respect to your account by any "Authorized Individual".

If you do not wish any individual, other than yourself, access to your account, you must indicate "No Access," and sign and date this Account Authorization form.

Patient Account:
The Authorized Individual(s) indicated below will have full access to the patient account until further notice is received from the patient to revoke such authorization. This form requires the signature of the patient, in order for the change(s) to take effect.

_____ **Full Access -** Financial inquiries, change of address or other identifying information (e-mail, addresses etc.), treatment inquires, account administration (appointments, cancellations, etc.)

Authorized Individual(s)
(1) Print Name: _____ Relationship: _____
(2) Print Name: _____ Relationship: _____
Patient Signature: _____ Date: _____

_____ **No Access** – I do not authorize anyone access to my account.

Patient Signature: _____ Date: _____

Communication Release

Dr. Quinta and staff are authorized to leave messages on my answering system, such as: home or office answering machine, cell or office voice mail, to communicate my appointment confirmation and/or any other non-clinical information. I understand that this authorization will remain in effect until it is revoked by me in writing.

_____ _____
Patient Signature Date