# TIMOTHY E. SIMMONS, D.D.S., P.A.

## ORAL AND MAXILLOFACIAL SURGERY

100 Walter Ward Blvd.
Box Hill Corporate Center, Suite 400
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410.569.9613 - 410.569.9614

Please sign the following so that we may process your insurance form:

I have reviewed the following treatment plan. I authorize the release of any information relative to this claim.

Signature ( patient or parent guardian if minor) _____

Date: _____

I hereby authorize payment of my group insurance benefits, otherwise payable to me, to the dentist ( this authorization applies only to non-participating dentist. Claim payments are mailed directly to participating dentists.)

Signature

_____