



I \_\_\_\_\_ consent to have Dr. Peter J. Samuels and/or Dr. Julie C. Berger discuss my dental treatment with insurance companies, referring doctors, referral doctors, dental colleagues, physicians, process my photos with an outside laboratory, and to use my case in lectures and teaching. I give consent for Samuels Dental Arts office staff to confirm my dental appointments with my spouse or family member or by answering machine and by reminder postcard. I understand Samuels Dental Arts will file my insurance form electronically and I do give consent for this submission.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **Samuels Dental Arts**

1650 Biglerville Road  
Gettysburg, PA 17325

Phone: 717-334-0555  
Fax: 717-334-9487