DENTAL SMILES OF LIVONIA, P.C. · 33044 FIVE MILE ROAD · LIVONIA, MI 48154 (734) 525-2552

PAYMENT AUTHORIZATION

I authorize Kristal Greniuk-Wioncek D.D.S. PLLC, to charge my credit card or debit card for any balance still owing on my account 45 days from the date of service. I understand that I am responsible for any balance due for services my family or I have received regardless of insurance benefits and /or estimate

CREDIT CARD AUTHORIZATION

VISA MASTERCARD DISCOVER DEBIT

Bank Name________________________________ Card Type_______________________________

Account Number______________________________ Exp. Date______________________________

Responsible Party Name____

Patient Name__________________________ Address_______________________________________

City________________________________ State_______________ Zip________________________

Card Holder's Signature_______________________________________ Date____________________

INSURANCE ASSIGNMENT OF BENEFITS

I hereby authorize payment of the dental benefits otherwise payable to me directly to Kristal Greniuk-Wioncek D.D.S.

Insured's Signature____________________________________

Staff Signature____

Dr.'s Initials___________________ Date___________________

The above authorizations expire one year from the date of signature.