PATIENT EASY PAY CONSENT

I, _____, as the responsible party or as the durable power of attorney (DPOA), medical power or attorney (MPOA), financial power or attorney (FPOA) or guardian of _____ authorize Michigan Geriatric Dental Care to charge my credit/debit card for the balance of charges not paid within 30 days.

Not to exceed $ _____

- ☐ Monthly
- ☐ Semi-monthly
- ☐ Weekly
- ☐ Per Visit

Date(s) of Service ___ /___ /___ to ___ /___ /___

I have provided my insurance information to the provider listed above. I understand, as a service to me, all bills will be submitted to the dental insurance company provided and a bill will be sent to the insured/responsible party for full payment and insurance reimbursement will be paid directly to the insured.

_____ _____

Cardholder Signature Date

Patient Name:		
Cardholder Name:		
Cardholder Address:		
City:	**State:**	**Zip:**
Credit Card Number: **we accept all major credit cards**		
Expiration Date:	**Security Code:**	