Leigh E. Snyder D.D.S.

16869 E. Fourteen Mile Rd. Fraser, MI 48026
(586) 775-1490

Dental Insurance Claim Release And Authorization

I, _____, hereby authorize release of any information related to treatment, necessary to process my insurance claim.
Date:_____
Signature:_____

I acknowledge that my insurance contract is a contract between my insurance company and myself. If for whatever reason reimbursement for services rendered are not received by my doctor as expected, I accept the financial obligation for these fees.
Date:_____
Initials:_____

I hereby authorize payment to be made directly to LEIGH E. SNYDER D.D.S. I understand that I am directly responsible for charges incurred. Charges not paid within a 60 day period; commencing from date of treatment, will be applied to my credit card payable to Leigh E. Snyder D.D.S.
Date:_____
Signature:_____

Credit Card Type:
VISA MASTERCARD AMERICAN EXPRESS DISCOVER
Account Number:_____
Exp Date:_____ New Exp Date:_____