

STATEMENT

Remit To:
 Kirol Family Dentistry
 219 Oakland Avenue
 Rock Hill, SC 29730

IF PAYING BY CREDIT CARD, FILL OUT BELOW.

| | | |
|------------------------------|------------------------------|-----------------------|
| NAME(As it appears on card) | | TYPE OF CARD |
| CARD NUMBER | | AMOUNT |
| SIGNATURE | | EXP. DATE |
| Statement Date: 3/22/2023 | Balance Due Now: \$347.90 | Acct#: 8554 |
| DUE DATE: 8/31/2022 | | Amount Enclosed: |

If address has changed, please correct.

For Billing Questions, call: (803)328-2411

TO ENSURE PROPER CREDIT, PLEASE DETACH AND RETURN THIS PORTION OF THE STATEMENT WITH YOUR PAYMENT.

PLEASE RETAIN THIS PORTION OF THE STATEMENT FOR YOUR RECORDS

| Date | Patient | Code | Description | Debits | Credits | Balance |
|------|---------|------|---|--------|---------|----------|
| | | | Balance Forward >>>>>> | | | \$347.90 |

Aged balances reflect current values
 Est. Insurance reflects current values and will affect Balance Due Now

| |
|-----------------------|
| Balance Due: |
| \$347.90 |
| Est. Insurance |
| \$0.00 |
| \$347.90 |

| Current | 30 Days | 60 Days | 90 Days | On Contract | Est. Insurance |
|---------|---------|---------|---------|-------------|----------------|
| \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |

PLEASE PAY THIS AMOUNT

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