## Credit Card Authorization

I authorize **Your Name Dental** to charge my:

Visa  MasterCard  \_\_\_\_\_\_\_\_\_\_\_ (other)

# Option One \_\_\_\_\_ Cardholder Initials

To cover the balance of charges not paid by insurances within 60 days and not to exceed **$\_\_\_\_\_\_\_\_\_\_\_\_\_\_** for:

This visit only. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

All visits this year.

Monthly visits.

# Option Two \_\_\_\_\_ Cardholder Initials

To cover recurring charges (ongoing treatments) of **$\_\_\_\_\_\_\_\_\_** every month for a total of **\_\_\_\_\_ equal payments** beginning **\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_** (mmm-dd-yyyyy) and ending **\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_** (mmm-dd-yyyyy)

|  |
| --- |
| Patient Name: |
| Cardholder Name: |
| Name: |
| Address: |
| City: |
| State / Zip |
|  |
| Card Number:[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] [ ][ ] |
| Expiry Date: / CVC |
| I authorize the above-named merchant to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.  Cardholder Signature: / Date: |