Credit Card Authorization Form

I authorize _____to charge my credit card as detailed below:

- ❏ Please keep this signature on file for any estimated patient portion due at the time of service.
- ❏ Please keep this signature on file for any estimated patient portion due at the time of service and any unpaid balance after insurance payment.
- ❏ Authorized for estimated patient portion for this current treatment only.

Patient Name _____

Responsible party name _____

Address_____

_____

Phone # _____

Credit Card:

- ❏ Visa
- ❏ MasterCard

Card # _____ Expiration Date _____

Card holder signature _____ Date _____

Print name _____

Staff initials _____