DEBIT OR CREDIT CARD AUTHORIZATION FORM

I, FINANCIALLY RESPONSIBLE PERSON, understand I have chosen to assign my dental benefits to Dr. _____, and a claim form will be sent to my insurance company for treatment provided.

I further realize I am ultimately responsible for this payment regardless of my insurance company's willingness to pay a benefit for this claim.

I hereby authorize Dr. _____ to keep my signature on file and to charge my (circle one) Visa, MasterCard, or Debit Card account $ _____ on the _____ (date) of each month from _____ (date) to _____ (date) for any and all treatment fees not paid by my insurance carrier or myself within 45 days. I understand arrangements for any additional or unforeseen charges to my account will be discussed separately from this agreement.

_____ _____ _____ _____

Card Holder's Signature Date Witnessed Date

_____

Card Holder's Address 1

_____

Card Holder's Address 2

_____

Card Holder's Telephone Number

_____ _____

Credit Card Number Expiration Date

_____

Name as it Appears on the Card

_____

Social Security Number

For your privacy and protection this form will be kept in a secure location.