Authorization to Charge Credit/Debit Card

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YOUR PRACTICE NAME (on practice letterhead)

To authorize a one-time or recurring charge to your credit card for treatment services rendered, please complete and sign this form. We adhere to the highest standards for account data protection.

Patient Billing Information

Patient Name: ______________________________

If Patient under 18 years of age,
Guardian Name: ______________________________

Billing Address: ______________________________

City: ____________________ State: __________ ZIP: __________

Phone: ____________________ Fax: ____________________

Email: ______________________________

Credit Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Cardholder Name (on credit card): ______________________________

Credit Card #: ______________ Expiration: ______________

Credit Card Security Code: ______________ Amount: ______________

Please Check Appropriate Box:

☐ One Time Use - I hereby authorize (*Practice Name*) to charge the above card number in the amount indicated above. This is a one-time charge authorization. I am not authorizing (*Practice Name*) to set up my account for recurring billing. I prefer to pay by check or cash for all future treatment and understand if I want to pay by credit card in the future, I will be required to submit another credit card authorization form at that time.

☐ Recurring Billing - I hereby authorize (*Practice Name*) to charge the above card number on a periodic basis (monthly) in the amount of $______________.

Authorization:
I hereby authorize (*Practice Name*) to charge the above card number. I agree to either a one time use or recurring billing as selected above. To terminate the recurring billing process, if selected, I must cancel in writing. If so, I will remit payment by check, cash, or money order. I understand all cancellations regarding my account must be in writing.
I guarantee that I am the legal cardholder for this credit card account and that I am legally authorized to use it for a one time charge or recurring billing payments.

Signature of Cardholder: ______________________ Date: ______________________