

John Q. Dentist, D.D.S.

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Murrieta, CA 92562

(909) 678-9876

Pre-Authorized Credit Card Agreement

I authorize _____ to keep
(name of dental care provider)

my signature on file and to charge my account for:

- Balance of charges not paid by insurance within 60 days and not to exceed \$ _____ for:
 - this visit only.
 - all visits this year.

- Recurring charges (on-going treatments) of \$ _____
every _____ from _____ to _____
(frequency) (date) (date)

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the dental care provider.

Patient Name		Cardholder Name		
Cardholder Address		City	State	Zip

Card Type:	
<input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> American Express <input type="checkbox"/> Other _____	
Credit Card Account Number	Expiration Date
Cardholder Signature	Date