Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Patient Name: _____

Cardholder name, if different: _____

Billing Address, if different than patient:

_____

_____

Credit Card Type: _____ Visa/MC ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

Maximum Amount to Charge: $ _____ (USD)

I authorize University Park Family Dentistry to charge the maximum amount or less listed above to the credit card provided herein either when insurance has been received or 45 days from the date of service, whichever comes first. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

_____ This form is valid for any and all future visits with University Park Family Dentistry.
_____ This form is valid only for the date of service __

Cardholder – Please Sign and Date

Signature: _____

Date: _____