

# Automatic Credit Card Authorization Form



Patient Name \_\_\_\_\_

Location \_\_\_\_\_

**First Payment Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Payment Amount \$** \_\_\_\_\_

**Number of Month** \_\_\_\_\_

**Final Payment Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Final Payment Amount \$** \_\_\_\_\_

**Visa**       **Master Card**  
 **Discover**     **American Express**

**Card #** \_\_\_\_\_

**Expiration Date** \_\_\_\_/\_\_\_\_

**No need for CVV**

**Name** as it **appears** on card \_\_\_\_\_

Address patient receives statements: \_\_\_\_\_

**\*\*\*VERIFY THIS INFO\*\*\***

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ (Street) Phone \_\_\_\_\_

As a courtesy, Drs. Savastano and Dunn have provided you with an interest free loan with our office. The treatment fee (payments made to Drs. Savastano & Dunn) reflects services (braces and the maintenance of the braces) provided by Drs. Savastano and Dunn. Any procedures needed to aid in the orthodontic treatment such as extractions, exposures, oral surgery of any nature, fillings, restorative work, dental cleanings & x-rays, etc. are **not included** in this fee. This is the patient/guardian's responsibility to pay for these procedures to the rendering doctors not affiliated with this practice.

All patient and insurance balances must be paid in full prior to the removal of the appliances. This is the responsible party's responsibility to pay these balances off in full regardless of any payment arrangements and will be refunded by the insurance company directly any benefits that are due. If for any reason estimated insurance is not received, or there is a change from an indemnity plan to a discount plan the responsible party will assume the unpaid balance. Credit cards will automatically be processed on the first of each month, if the first falls on a weekend it may process that day or the next business day. It is your responsibility to notify us of any changes with your card and/or provide our office with anew credit card # for those that expire. Changes must occur 10 business days prior to processing date. Any requests made other than changing the credit card number will have a \$30.00 fee assessed. If for any reason credit cards are declined including expired cards there will be a \$30.00 fee added to your account. The credit card will be processed each day until charge is accepted or a new card has been presented and an imprint has been made of that card. By signing below you give Dr. Savastano & Dr. Dunn permission to charge your credit card/check debit card for reoccurring billing for your Orthodontic Treatment and agree to the terms mentioned above.

**Authorized Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Print Name as signed above: \_\_\_\_\_

**PLEASE AFFIX A CREDIT CARD IMPRINT HERE**