PRESERVATION DENTAL

AUTO-PAYMENT AUTHORIZATION FORM

Date: _____

Responsible Party:_____

Address: _____City: _____ State: _____ Zip:_____

Phone: _____

Patient Name (if other than Responsible Party): _____

Patient DOB: _____

I hereby authorize Preservation Dental to charge my credit card whenever there is a balance for services provided*. I understand this payment option is interest free and I am required to make payments as indicated:

☐ Weekly ☐ Monthly _____

Payment Amount

Weekly payments will be processed on Friday unless otherwise noted; Monthly payments will be processed on the 15th of each month unless otherwise noted.
** We will gladly make a courtesy call to confirm your credit card payment if requested.*

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ☐ Care Credit

Credit Card # _____ Exp. Date: _____

_____Billing Zip Code:_____
Name on Credit Card

Security Code: _____ Authorize Signature: _____

Date: _____ Print Name: _____

Date	Payment	Authorization Code	Balance

Special instructions:_____

_____