

2008 CREDIT CARD PAYMENT AUTHORIZATION

Name: \_\_\_\_\_  
(As it appears on the credit card)

In order to keep our treatment costs and clerical fees down, we require a credit or debit card number on file for those patients who choose to pay the estimated patient portion at the time of treatment instead of paying in full. This credit card number will only be used if there is an outstanding balance in your ledger not paid by you or your insurance company within forty five (45) days after services have been rendered. We will be courteous and mail you a receipt upon posting these charges. Also, this card number may be used at your convenience for quick and easy payments for future appointments and purchases.

I, the undersigned authorize Aspen Leaf Dentistry, P.C. to charge my:

Master Card  Visa Card

Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Last Three Numbers in Signature Line: \_\_\_\_\_

Pursuant to the terms herein, Aspen Leaf Dentistry is authorized to the above referenced credit/debit card for services 45 days past due, thereby agreeing to pay amounts due and owing according to the card issuer agreement (merchant agreement if voucher).

\_\_\_\_\_  
Cardholder Name (Print)

\_\_\_\_\_  
Cardholder Signature

\_\_\_\_\_  
Today's Date

\*Please call me if charging more than \_\_\_\_\_ dollars.\*