COMMONWEALTH ORTHODONTICS

Jeffrey W. Beyer, DDS
Specializing in Orthodontics & Dentofacial Orthopedics

AUTHORIZATION FOR CHARGE TO CREDIT/DEBIT CARD

Patient Name: _____

Responsible Party Name: _____

I. Authorization

The undersigned hereby grants permission to Commonwealth Orthodontics to charge the credit card indicated in the amount(s) set forth in this agreement.

II. Payments

Payments of $_____ will be drafted on the _____ of each month or the following business day of each month beginning on ____/____/____ for a total of _____ months.

III. Patient Responsibility

It is the responsibility of the undersigned to inform Commonwealth Orthodontics of any changes, cancellations and/or renewals to the credit card listed below. If a charge should be declined, we will attempt to contact you to inform you of the situation. However, payments are still due according to the financial contract. Any additional fee or late fees will apply if payment is not received on time. If any changes are to be made to your auto-charge account, a new form must be completed.

Initial here _____.

CREDIT/DEBIT CARD INFORMATION

Credit/Debit Card Type: ☐ Visa ☐ MasterCard

Billing Address: _____

Account #: _____

Expiration date: _____

* ONLY FOR FLEXIBLE SPENDING / MEDICAL SAVINGS ACCOUNT*

☐ Print and I will pick up at my appointments

☐ Please fax receipt to : _____

Authorized Signature: _____ Date: _____