Credit Card / Payment Authorization Form

Please Complete the Information Below and Sign:

Print Name _____ **Date** _____ **Phone Number** _____

Payment Type

☐ Credit ☐ Debit ☐ American Express ☐ Master Card ☐ Visa ☐ Discover

Name on Card _____ **Expiration** _____ **Card Number** _____ **V Code** _____

Billing Address

_____

_____

In signing below, I authorize, Dr. Andrew Greenberg, DMD, to initiate charges to the credit card indicated above for the total amount due. I also agree to the payment terms established on the Consent for Service Agreement outlining the cancellation and no-show policy reprinted below, as well as any additional charges related to services provided.

Once an appointment is scheduled, YOU WILL BE EXPECTED TO PAY FOR THE ENTIRE APPOINTMENT UNLESS 24 HOURS' NOTICE IS PROVIDED WHETHER YOU ARE A NEW OR EXISTING PATIENT, or we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies for not provide reimbursement for cancelled or no-show appointments. THERE WILL BE A CHARGE FOR LATE CANCELLATION WITHOUT 24 HOURS' NOTICE.

I understand that I may modify or cancel recurring charges upon written or verbal notice at any time prior to services rendered or scheduled.

Cardholder Signature _____ **Name** _____

Date _____