ROSENBERG ORTHODONTICS, PC

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Orthodontic Specialists

Credit Card Authorization Form

Patient Information

Patient Name: _____ **Account #:** _____

Responsible Party Name: _____

Responsible Party Address: _____

Payment Information

Cardholder Name: _____

Card Number: _____ **Exp:** _____

Amex ☐ Discover ☐ MasterCard ☐ Visa ☐

Billing Address: _____
(Check if same as above) ☐

Balance Information

☐ Balance of charges not paid by insurance within 90 days and not to exceed $_____

☐ Recurring charges (on-going treatments) of $_____ on the 15th of every month from _____ to _____

Signature

Cardholder Signature: _____ **Date:** _____

I authorize Rosenberg Orthodontics, PC to keep my signature on file and to charge my credit card account as indicated above. This authority will remain in effect until Rosenberg Orthodontics, PC is notified by me in writing to cancel it in such time as to afford Rosenberg Orthodontics, PC and my financial institution a reasonable opportunity to act on it, or until the balance is paid in full.

For office use only: Staff Initials _____ Office Location _____ Last payment date _____

Please mail or fax form to:
Rosenberg Orthodontics, 435 Willard Ave., Newington, CT 06111