STUART PROSTHETIC
DENTISTRY

To authorize a one-time or recurring charge to your credit card for treatment services rendered, please complete and sign this form. We adhere to the highest standards for account data protection.

PATIENT BILLING INFORMATION

Patient's Name: ___________________________________ Guardian (if under 18): _______________________________________

Billing Address: ____ City____________________ State_____ Zip________

Email: ____________________________ Cell Phone: ___________________ Work Phone: ________________________

CREDIT CARD INFORMATION

Credit Card Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name: ____

Credit Card Number: ____ EXP: _______________________

Security Code: ____ Amount: $__________________

PLEASE CHECK APPROPRIATE BOX

☐ **ONE TIME USE** – I hearby authorize Stuart Prosthetic Dentistry to charge the above credit card number amount in the amount indicated above. This is a one-time charge authorization. I am *not* authorizing Stuart Prosthetic Dentistry to set up my account for recurring billing. I prefer to pay by check or cash for all future treatment and understand if I want to pay by credit card in the future, I will be required to submit another credit card authorization form at that time.

☐ **RECURRING BILLING** – I hearby authorize Stuart Prosthetic Dentistry to charge the above credit card number on a periodic basis (monthly) in the amount of $ _____________________.

AUTHORIZATION

I hereby authorize Stuart Prosthetic Dentistry to charge the above card number, I agree to either a one-time use or recurring billing as selected above. To terminate the recurring billing process, if selected, I must cancel in writing. If so, I will remit payment by check, cash, or money order. I understand all cancellations regarding my account must be in writing. I guarantee that I am the legal cardholder for this credit card account and that I am legally authorized to use it for a one-time charge or recurring billing payment.

Signature of Cardholder: ____ Date: ___________________