East Taylor Dental Associates
family, cosmetic & implant dentistry

PAYMENT AUTHORIZATION

Sign and complete this form to authorize East Taylor Dental, PC to make a one-time debit to your credit card listed below. THIS FORM MUST BE COMPLETED BY THE CARDHOLDER.

By signing this form you give East Taylor Dental, PC permission to debit your account for the amount indicated below. This is a permission for a **single transaction only,** and does not provide authorization for any additional unrelated debits or credits to your account. Any future payments you intend to make must be pre-authorized at that time.

Please complete the information below:

I _____ authorize East Taylor Dental, PC to charge my credit card
(cardholder name)

account indicated below for $ _____ on _____.
(amount) (date)

This payment is for _____
(description of treatment)

on behalf of _____, who is my _____.
(patient name) (relation to cardholder)

Billing Address _____ Phone#: _____

City, State, Zip _____ Email _____

Account Type: ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER

Cardholder Name _____

Card Number _____

Expiration Date _____ CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

PRINTED NAME _____ TITLE _____

ELECTRONIC SIGNATURE _____ DATE _____

I, the above subscriber, authorize East Taylor Dental, PC to charge the credit card indicated in this authorization form. This payment authorization is for the treatment described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the aforementioned Agreement and its terms that have hereby been underwritten and secured in pursuance of the same, for the above-named patient.