

CREDIT CARD AUTHORIZATION

I authorize Fountain Plaza Family Dental, Dr. Wallace Bellamy to keep my signature on file and to charge my credit card account for:

Balance of charges not paid by insurance within 60 days and not to exceed

\$ _____ for:

this dental visit only

all dental visits this year

Recurring charges (ongoing treatments) or payments of \$ _____ on

_____ of each month. (notes) _____

(Date)

I understand that this form is valid for one (1) year unless I cancel the authorization through written notice to the office of Dr. Bellamy.

Patient's name: _____

Cardholder's name: _____

Cardholder's address _____ Zip _____

(Street)

(City)

Account Number: _____ Exp Date _____

Cardholders Signature _____ Date _____