Recurring Credit Card Payment Authorization

You authorize regularly scheduled charges to your credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I, _____, authorize Dental Implant Center, PLLC. to charge my Credit Card indicated below for _____ on the _____ of each month effective _____ until the total amount of _____ is paid in full.

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____

CC Number _____ Expiration Date ____ /____

CVV ____ Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Dental Implant Center, PLLC. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

Patient's Printed Name: _____

Cardholder's Printed Name (if not the patient): _____

SIGNATURE _____ DATE _____
(Cardholder's Signature)