Monthly Agreement to Debit a Credit Card

I give the My East Cobb Dentist, PC permission to automatically
debit $ _______ . _____from the below listed credit card every month.

Please apply these funds to the account of:

Patient Name: ____ (print clearly)
Responsible Party Account: ____

I understand that these funds are for future dental expenses incurred by the above named patient. In the case that there are any problems with my credit card payment, I agree to pay all collection costs and reasonable attorneys fees incurred in attempting to collect on this or any future outstanding account balances for the above named patient.

Name of the Bank that issued this credit card: _____________________________
Bank Telephone Number: _____________________________
Circle one: Visa MasterCard Discover
Credit Card Number: _____________________________
Credit Card Expiration Date: _____________________________
Card Verification Code _____________________________

I certify that this is my credit card and that I am legally authorized to give permission for its use. By signing this agreement and by photocopying my credit card, I hereby give my fully-informed consent to treat the above named patient and I agree to allow My East Cobb Dentist, PC to debit my credit card for charges incurred by this patient. I realize that once the services have started for the above named patient that these funds will be applied the payment of these services and that I will not be entitled to any refunds. I agree not to dispute the resultant charges.

Cardholder Signature: _______________________________________ Date: _________
Cardholder Printed Name: _______________________________________

As the credit card holder, I also authorize My East Cobb Dentist, PC to charge this credit card for **future** dental services which are **verbally approved** by me for the above named patient

Authorization Valid Until: ______ / ______ Initials Here: _______________

Completion of this authorization form helps My East Cobb Dentist, PC to protect you from credit card fraud. My East Cobb Dentist, PC will keep all information entered on this form strictly confidential.

Once you have completed this credit card authorization form, please fax a signed copy to My East Cobb Dentist, PC **fax line 770-579-6100** or scan and email to doctorklein@yahoo.com. Be sure to include the copies of the front and back of your driver's license and the credit card being used. (Light and **legible** copies of the front & back of the credit card and ID are required with this form.) Dark copies are rejected. Any questions can be verbally answered by calling our voice **line at 770-579-6400**.