CREDIT CARD AUTHORIZATION FORM I, _____, hereby authorize Elite Dental PC., to submit electronic claims on my behalf and agree to assign the payment directly to Elite Dental PC. I understand that my dental benefit reimbursement plan is an agreement between my insurance carrier and myself. I further understand that I am responsible for any service fees or balances that may not be covered by my dental benefit plan and any differences resulting from the amount billed, including estimated copayments already collected and the amount covered by my plan. I authorize Elite Dental PC., **to debit my credit card account for payment of any account balance remaining on my account once the insurance check is posted or denied by the insurance company. I authorize Elite Dental PC., to debit my credit card account for any remaining balance on my account not paid by my insurance company.**

Credit Card Authorization Form PLEASE PRINT OUT AND COMPLETE THIS AUTHORIZATION AND RETURN TO US. All information will remain confidential.

Cardholder Name: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa ____ Mastercard ___ Discover ____ AmEx _____

Credit Card Number: _____

Expiration Date: _____

Card Identification Number (last 3 digits located on the back of the credit card): _____

I authorize Elite Dental PC to charge the agreed amount listed above to my credit card provided herein. I agree that I will pay for this treatment in accordance with the issuing bank cardholder agreement.

Keep my card on file to be charged in case of a past due amount: Yes

Copy of receipt either emailed or faxed: email/fax# _____

Cardholder – Sign, Date and Print Name Below:

Signed: _____

Name: _____ Dated: _____