Credit Card Authorization Form

I ____________________________ authorize Pine Ridge Dental to charge my credit card or debit card as detailed below:

Patient Name: ____

Responsible Party Name ___________________________________

Zip code where cc is billed ___________________________________

Email address for receipt: ___________________________________

Credit Card Type: __________________

Credit Card # __________-_________-__________-__________

Exp Date_____________

Card ID number (last 3 digits on the back) $______________________

Signature________________________________

______ I understand that the estimated fee will be charged prior to my appointment

______ I am aware that if I cancel appt less than 72 hours there is a $100 fee

______ I am aware that fees will be discussed prior to additional treatment

______ I am aware that I will be emailed a receipt

______ I understand that any additional procedure fees and amount not covered by insurance will be auto charged to my credit/debit card.