Credit Card on File Authorization

We understand that convenience is not often associated with today's health care environment. Our Practice not only focuses on excellent health care service but also how to provide service as cost and time effectively as possible. We have found that collecting all known liability at the time of service is not only beneficial for the practice, but experience has proven that our patients appreciate knowing they will not have to worry about delayed billing or payments.

We provide secured methods of accepting your payment at the time of treatment and for keeping your credit card on file to handle any remaining balance after insurance company reimbursement.

I _____ authorize **Dental Care Center of South Kansas City** to keep my signature and credit card information on file and to charge my account for balances that remain unpaid sixty (60) days following the service not to exceed _____**.**

I understand the provider is offering this as a courtesy and I may pay my balance in full at any time and cancel this agreement. I am authorizing the use of this card for:

Patient Name:

Card Holder Name:

Card Holder Address:

Type of Credit Card: #:

Expiration Date: Security Code:

Signature: Date: