Authorized Credit Card Payment Form

I authorize, Dr. Jonathan L. Ferencz D.D.S, Dr. Lawrence E. Brecht., D.D.S., Dr. Debra H. Cohn, D.D.S. to keep my signature on file and to charge my MasterCard, Visa or American Express account as indicated below:

Check One: MasterCard Visa American Express

The balance due on my account $ ___________

Recurring charges (on-going treatments) of $ ___________

…every ______________________ from ____________________ to ____________________
(frequency) (date) (date)

Account Number: _____________________________ Security Code: ____________________

Expiration Date: _____________ _____________
(month) (year)

Cardholder's Signature:__________________________ Today's Date: ____________________

Cardholder's Name as it appears on card: ____

Cardholder's Billing Address: ____

City: _______________________________________ State: _____________ Zip: ___________

Home Telephone: (_____) ______________________ (include area code)

Work Telephone: (_____) ______________________ (include area code)