# Monthly Agreement to Debit a Credit Card

I give the Atlanta Dental Group 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 the Atlanta Dental Group 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 the Atlanta Dental Group 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 the Atlanta Dental Group PC to protect you from credit card fraud. The Atlanta Dental Group 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 the Atlanta Dental Group PC fax line **404-873-2231**. 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 **404-874-7428**.