

Credit Card Authorization Form

I authorize **Dr. Calabria's Office** to charge my credit card as detailed below:

- Monthly payments of the following amount \$_____.
- Please keep this signature on file for any estimated patient portion due at the time of service.
- Please keep this signature on file for any estimated patient portion due at the time of service and any unpaid balance after insurance payment.
- Authorized for estimated patient portion for this current treatment only.

Patient Name _____

Responsible party name _____

Address _____

Phone # _____

Credit Card: Visa MasterCard Discover American Express

Card # _____ Expiration Date _____

Card holder signature _____ Date _____

Print name _____

Staff initials _____