Recurring Credit Card Payment Authorization for Orthodontic Treatment Account.

You authorize periodic scheduled charges to your credit card based on your Orthodontic Contract agreement for monthly payments.
You will be charged the amount indicated below each billing period. A monthly statement with your payment will be provided to you, and the charge will appear on your credit card statement. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 5 days prior to the payment being collected.
Please check off your preference for the payment be debited the 1st or the 15th of each month.

I _____authorize **Patricia Crespo DDS.,PLLC** to charge my
(Cardholder's Name)

Credit Card indicated below for $_____ on the ☐ 1st or ☐ 15th of
(Amount $)
each month until Orthodontic contract of _____ is paid in full.
(Patient's Name)

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____
Account/CC Number _____
Expiration Date ____ /____
CVV ____
Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **Patricia Crespo DDS PLLC** in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____
(Cardholder's Signature)