**Healthy Smiles Dental Credit Card Authorization Form**

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| --- | --- |
| CREDIT CARDHOLDER INFORMATION | |
| NAME ON CREDIT CARD |  |
| TYPE OF CREDIT CARD | ☐ VISA ☐ MC ☐ AMEX ☐ DISCOVER ☐ OTHER |
| CARD NUMBER |  |
| EXPIRATION DATE |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| BILLING ADDRESS | |  | | | |
| CITY |  | STATE |  | ZIP CODE |  |
| PHONE |  | EMAIL |  | FAX |  |

|  |  |
| --- | --- |
| AUTHORIZED USER OF CREDIT CARD | |
| NAME |  |
| COMPANY |  |
| PHONE NUMBER |  |
| EMAIL ADDRESS |  |
| DRIVER’S LICENSE NUMBER |  |
| RELATION TO OWNER |  |
| TYPE OF CHARGES |  |
| AUTHORIZED AMOUNT |  |
| DATE OF CHARGE |  |

**Authorization of Card Use**

☐ I certify that I am the authorized cardholder and signer of the credit card referenced above. I certify that all information above is complete and accurate.

☐ I hereby authorize collection of payment for all charges indicated above. Charges may not exceed the amount listed above in the “AUTHORIZED AMOUNT” field. I understand this is only for up to this amount during the time period “DATE OF CHARGES” referenced above. If additional charges are going to be authorized a new form will have to be completed.

|  |  |  |  |
| --- | --- | --- | --- |
| CARDHOLDER NAME |  | | |
| SIGNATURE |  | DATE |  |