



**DENTAL
ASSOCIATES
OF WALPOLE**

Family ◦ Specialty ◦ Care

AUTHORIZATION FOR AUTOMATIC CREDIT CARD CHARGE

I authorize Dental Associates of Walpole to charge my credit card for treatment proposed to me on / / .

Date: _____

Patient Name: _____ Chart#: _____

Check one: ___ M/C ___ Visa ___ Discover ___ American Express

Cardholder Name: _____

Card #: _____ Expiration Date: _____

Billing Address of Credit Card Statement: _____

Total Amount to be charged: _____

Monthly Payment Amount: _____

of Months to be charged: _____

Payment application date: ___ 1st ___ 15th of month (choose one)

Signature of Responsible Party: _____

Accepted By: _____

Approved By: _____