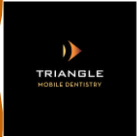
Triangle Mobile Dentistry



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Credit Card Authorization Form

Patient Financial Responsibilities: PAYMENTS ARE DUE IN FULL AT THE TIME OF SERVICE. At the beginning of treatment, we request you secure your account with a credit card. This card will only be charged with your permission below.
Please note due to the nature of the care, we cannot give exact amount of the treatment prior to seeing the patient. All fees are given are only an Estimate
(Debit cards can be used if they have a major credit card logo.)

Credit Card: □ Visa □ MasterCard □ Discover □ American Express

Patient's Name: ________________________________

Name on Card: _________________________________

Acct #: ______________________________________

Expiration: ___/___/______ Security Code: _________

Billing Address: ____

City, State, ZIP Code: ____

Do you require an itemized/HSA receipt? ___________:

_________ I agree to allow Triangle Mobile Dentistry to charge my credit card on file for the amount due at each appointments.
I have read this Financial Policy and I agree to the terms and conditions outlined within this policy. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Triangle Mobile Dentistry. I also agree to pay according to my credit card issuer agreement.

Patient/Responsible Party Signature: ________________________ Date:_____ ____________

Name ____ Relation To Patient ;_______________
(Please Print)