ROSENBERG ORTHODONTICS, PC

Barry M. Rosenberg, D.M.D. • Janel L. Johnson, D.M.D.
Daenya T. Edwards D.M.D. • George Baranowskyj, D.D.S.
Orthodontic Specialists

Credit Card Authorization Form

Patient Information

Patient Name: ______________________________ **Account #:** __________

Responsible Party Name: ______________________________

Responsible Party Address: ______________________________

Payment Information

Cardholder Name: ______________________________

Card Number: ______________________ **Exp:** ________

☐ Amex ☐ Discover ☐ MasterCard ☐ Visa

Billing Address: ______________________________

Would you like a receipt? ☐ YES ☐ NO

Balance Information

☐ Balance of charges not paid by insurance within 90 days and not to exceed $__________________

☐ Recurring charges (on-going treatments) of $__________________ on the 15th of every month from ________________ to ______________

Signature

Cardholder Signature: ______________________________ **Date:** ______________

I authorize Rosenberg Orthodontics, PC to keep my signature on file and to charge my credit card account as indicated above. This authority will remain in effect until Rosenberg Orthodontics, PC is notified by me in writing to cancel it in such time as to afford Rosenberg Orthodontics, PC and my financial institution a reasonable opportunity to act on it, or until the balance is paid in full.

For office use only: Entered ________ Last payment date ________

Please mail or fax form to:
Rosenberg Orthodontics, 435 Willard Ave., Newington, CT 06111
Fax: (860) 666-6138

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