DR. JAMES A. TETZ, D.M.D., INC.

AUTOMATIC CREDIT CARD & DEBIT CARD PAYMENTS

For Orthodontic Treatment of Patient:_____

We invite you to join our convenient, automatic credit card payment program. Dr. James Tetz D.M.D., Inc. will automatically charge your orthodontic payments to your credit card when payment is due.

Instructions:
By Mail: Please complete and sign the authorization agreement. Return in the enclosed envelope prior to your starting appointment.
In Person: Complete and sign the authorization agreement and bring it prior to the starting appointment or to the starting appointment.
By Fax: Complete and sign the authorization agreement and fax to **937-324-0365**

AUTHORIZATION AGREEMENT FOR DR. JAMES TETZ D.M.D., INC. CREDIT CARD PAYMENTS

I (we) authorize and request Dr. James Tetz D.M.D., Inc. to initiate electronic debit entries or use any other commercially accepted practice to charge my (our) credit card account indicated below. I (we) authorize and request the credit card company to honor the debit entries initiated by Dr. James Tetz D.M.D., Inc. and debit these charges to that account. This authorization relates to all payments required on my (our) orthodontic account identified below and related contract. It also covers changes in amounts and payments due because of additional agreements between me (us) and Dr. James Tetz, D.M.D., Inc. that relate to the contract. This authorization will remain in effect until all amounts owed related to the contract are paid in full, or until I (we) cancel this authorization. To cancel, I (we) must notify Dr. James Tetz, D.M.D., Inc. and the credit card company in writing far enough in advance to give Dr. James Tetz, D.M.D., Inc. and the credit card company a reasonable opportunity to act.

Signature of Card Holder: _____Date: _____

Type of Credit Card: ☐ Visa ☐ MasterCard ☐ Discover
(WE DO NOT ACCEPT AMERICAN EXPRESS)

Name as it exactly appears on the credit card:_____

Credit Card Account No._____Expiration Date: _____

Three-digit security code (on back)_____Amount to Withdraw_____ Due Date:_____Of Each Month

FOR OFFICE USE ONLY
Deduction Start Month/Year: _____ Deduction End Month/Year: _____

*If a payment is due on a weekend or holiday, Dr. James Tetz D.M.D., Inc. will initiate a debit entry and credit your account on the next business day.

Billing address: _____ Billing Zip Code: _____

Credit Card Holder Contact Phone #:_____

Springfield: 2100 E. High St. Suite 105 Springfield, Ohio 45505 (937) 324-5700
London: 66 W. High St London, Ohio 43140 (740) 852-5050