Mission Valley Dental Clinic
Michael Ruhkala, D.D.S.
P.O. Box 640
215 Mtn. View Dr.
St. Ignatius, MT 59865
406-745-3951

Pre-Authorized Credit Card Agreement

_____

Patient Name | Cardholder Name

_____

Billing Address | City, State, Zip

Card Type:

☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

_____

Credit Card Account Number | Exp. Date | Security Code

_____

Cardholder Signature | Date

I authorize ***Dr. Ruhkala*** to keep my signature on file and to charge my account for:

$ _____ or balance due after insurance.

- ☐ A one-time charge – accruing no interest charges.
- ☐ Payments broken into segments – check one below (may accrue 18% APR):
  - ☐ 2 payments
  - ☐ 3 payments

Each payment will be in the amount of: $ _____

Total Payments: $ _____

Mail receipt? YES NO

I understand that this form is valid until the balance is paid in full unless I cancel the authorization through written notice to the dental care provider. I assign my insurance benefits to the provider listed above.

_____

Patient Signature | Date | Employee Signature