Credit Card Charge Authorization Form

I (we) hereby authorize Ormond Beach Dental Group to charge my Credit Card listed below, and, if necessary, initiate adjustments for any transactions credited/debited in error. If Recurring, This authority will remain in effect until Ormond Beach Dental Group is notified by me (us) in writing to cancel it in such time as to afford Ormond Beach Dental Group and Credit Card company a reasonable opportunity to act on it.

_____

(Name - PLEASE PRINT AS APPEARS ON CARD)

_____

(Address - PLEASE PRINT)

_____

(Phone Number - PLEASE PRINT)

_____

(Email - PLEASE PRINT)

Please circle one: Visa / MasterCard Amex

Account Number: _____

Card Code _____

Expiration Date:_____

Charge Amount: $_____

Frequency (please circle one or fill out your own schedule):

One Time Charge - Bi-monthly - Monthly - Quarterly or _____

_____ _____

(Signature) (Effective Date)

Ormond Beach Dental Group
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Ormond Beach Florida 32174
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Fax 321-445-5364