
# EASY PATIENT PAY AUTHORIZATION OPTION

Preauthorized Credit Card Signature "On File" For Health Care Expenses

This form will afford our patients the opportunity to pay a bill without waiting for a monthly statement. Thank you for assisting our practice in our continued efforts to reduce the costs of providing your healthcare through the reduction and elimination of paper billing statements and or statement fees.

## PLEASE CHECK ***ONE*** OF THE FOLLOWING OPTIONS:

◯ My signature below authorizes **Pinnacle Peak DentalCare** to keep my signature securely on file and to ***charge my card for balances*** not paid by insurance. If the balance exceeds $100.00 I will be called prior to the card being charged.

Cardholder Name: _____

Credit/Debit Card Number: _____

Expiration Date:_____/_____

Security Code: _____

Billing Address: _____

Billing City: _____ Billing State: _____ Billing Zip Code:_____

Patient or Patient's Name: _____

Cardholder Signature: _____ Date: _____

## OR

◯ I am signing below because I elect ***not*** to have my credit card kept securely on file. I understand that I may be charged a statement processing fee of ***$1.50*** for each statement that is sent.

Signature:_____Date:_____