CREDIT CARD PRE-AUTHORIZATION

Albert Joaquin Jr D.D.S.
18203 Dixie Hwy
Homewood IL 60430
(708) 798-8888

For your convenience you may pay your account balance with your credit card. Please complete the information below:

Patient Name _____

I authorize the office of Albert Joaquin DDS to charge my credit card account for my balance due for:

❑ Recurring charges for ongoing treatments:

$_____ per month
(Amount)

from _____ to _____
(date) (date)

❑ Past Services, in the following amounts and dates:

$_____ on _____
(Amount) (date)

$_____ on _____
(Amount) (date)

$_____ on _____
(Amount) (date)

❑ Today's charges only:

$_____ per month
(Amount)

from _____ to _____
(date) (date)

❑ All visits this year

Please Charge My ☐Visa ☐Mastercard ☐Discover ☐CareCredit

Charge Account Number _____ Exp _____

Cardholder Name (please print) _____

I understand that this form is valid for one year unless I make other arrangements with this office.
I may also cancel the authorization at any time with written notice to this office.

Cardholder Signature _____