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# Credit Card Charge Authorization Form

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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)

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**Ormond Beach Dental Group**  
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