Credit Card Pre-Authorization for Dental Treatment Form

Please complete & return with SIGNATURE

Via Email: service@dentaltlc.com or Via Fax: 404.255.0923

CareCredit
Patient Payment Plans

I authorize Dental TLC to keep my signature on file and to charge my Visa, MasterCard, American Express or Discover as indicated below:

Check One: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover ☐ Care Credit

☐ Balance of Charges not estimated to be paid by insurance and not to exceed ___________.

Indicate one:

☐This visit only.

☐All visits this year.

☐ Recurring charges (on-going treatment) of $____________

Every ____________________ From _________ To _________.

(Frequency) (Date) (Date)

For CARE CREDIT ONLY: Please indicate how long you would like to do the no interest:

☐ 6 months ☐ 12 months

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

____

Patient Name

____

CardHolder Name

____

CardHolder Billing Address

____

City State Zip

______________________________Mo.________Yr. ____

Account Number Expiration Date Security Code (3 digits on BACK of Visa, MC, Disc/ 4 digits on FRONT of Amex, no code needed for Care Credit)

____

CardHolder Signature Date