

**EASY PAY CONSENT**

**This is optional and created for your convenience to avoid having to mail checks.**

***I authorize to keep my signature on file and charge my credit card  
To cover any balances from my dental care.***

Patient's Name \_\_\_\_\_

Cardholder's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Street Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Credit / Debit Card Number: \_\_\_\_\_

Expiration: \_\_\_\_/\_\_\_\_/\_\_\_\_.

Security Code: \_\_\_\_\_

Visa

Mastercard

American Express

Discover

Cardholder's Signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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