CREDIT CARD
AUTHORIZATION

Patient Name_____

I authorize Mountain View Dental to use the payment method listed below for the estimated patient portion above what my dental benefits cover. I acknowledge that any balance remaining after 90 days or not paid by my dental benefits carrier will be my responsibility to pay.

_____ _____

Patient, Parent, or Guardian Signature Date

Cardholder Information

Name: _____

Billing Address: _____

City: _____ State: _____ Postal Code: _____

Email: _____

Phone Number: _____ Best Time to Call? _____

Credit Card Information

Credit Card Type: ☐ VISA ☐ Master Card ☐ AMEX ☐ Discover ☐ HSA

Card Number: _____

Expiration Date: _____/_____ Security Code: _____

Cardholder Signature:_____

Financing (if applicable)

I authorize Mountain View Dental to charge my credit card $_____

☐ One Time ☐ Weekly ☐ Every Other Week ☐ Monthly

On Specified Dates: _____

Duration: _____ months

First Payment Date: _____ Last Payment Date: _____

_____ _____

Patient, Parent, or Guardian Signature Date