SPRINGFIELD
FAMILY DENTAL

Credit Card Payment Authorization

You authorize regularly scheduled charges to your Credit Card. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your Credit Card Account Statement. You agree that no prior-notification will be provided to you each month unless the date or amount changes, in which case you will receive notice form us at least 10 days prior to the payment being collected. **20% of total fee is required upfront in order to start any form of treatment.**

I, _____ authorize **Springfield Family Dental** to charge my Credit Card below for treatment totalling $_____, divided over _____ months, beginning on _____ (date) and charged on the first of every month.

Each payment will be $_____ per month.

20% Down Payment due today: $_____

Goods / Services Rendered: _____

Billing Details

Billing Address _____ Phone # _____

City, State, Zip _____ Email_____

Credit Card Information

(circle one)

Visa
Mastercard
AMEX
Discover

Cardholder's Name: _____

Credit Card Number: _____-_____-_____-_____

Expiration Date _____/_____

Security Code (CVV) _____

Individual's Signature _____ **Date** _____