Pinnacle Peak Dental Care

EASY PATIENT PAY AUTHORIZATION

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

This form will afford our patients the opportunity to pay a bill without waiting for a monthly statement. Thank you for assisting our practice in our continued efforts to reduce the costs of providing your healthcare through the reduction and elimination of paper billing statements and/or statement fees.

PLEASE CHECK ***ONE*** OF THE FOLLOWING OPTIONS:

◯ My signature below authorizes **Pinnacle Peak Dental Care** to keep my signature securely to charge my card for balances not paid by insurance. If the balance exceeds $100.00 I will be call prior to the card being charged.

Cardholder Name: _____

Credit/Debit Card Number: _____

Expiration Date: ____/____

Security Code: _____

Billing Address: _____

Billing City: _____ Billing State: _____ Billing Zip Code: _____

Patient or Patient's Name: _____

Cardholder Signature: _____ Date: _____

OR

◯ I am signing below because I elect ***not*** to have my credit card kept securely on file. I understand that I may be charged a statement processing fee of ***$1.50*** for each statement that is sent.

Signature: _____ Date: _____