SENIOR smile
Namita K. Thapar-Dua, DDS
Providing Mobile Dental Care
Serving Maryland, DC & Virginia
301.875.7477

CREDIT CARD AUTHORIZATION FORM

(Patient's credit card OR on behalf of the Patient via POA/Guardian)

By signing this form, you agree that the balance pending from the services rendered on an approved (approval given verbally or written) appointment, will be the patient's or their power of attorney/guardian's responsibility and the credit card on file will be charged that same day.

You will receive a receipt upon the credit card being charged for those services rendered for that day's appointment and will receive an email confirmation or receipt in the mail.

I, _____, Family Member, Power of Attorney or Guardian of _____ (Patient Name), certify that this is my credit card and that I am legally authorized to give permission for its use. By signing this form, I authorize SENIOR SMILE with Namita K. Thapar-Dua, DDS to charge my credit card an amount not to exceed the charges mentioned on the consent form or discussed via treatment plan on the phone or written. I agree to pay the amount so charged in accordance with my credit card issuer agreement. In the event that there are any problems with my credit card payment, I agree to pay all collection agency costs and reasonable attorney fees incurred in attempting to collect on the account balance.

CREDIT CARD BEING USED: ___VISA ____MASTER CARD ____AMEX ___DISCOVER

CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____

SECURITY CODE (3 digits located on the back for VISA/MC/DISC OR 4 digits on the front for AMEX): _____

NAME ON THE CARD: _____

SIGNATURE: _____

EMAIL TO SEND RECEIPT: _____