Signature on File

"CONFIDENTIAL" Authorization Form

Patient Name (If this should apply to other family members, please list.)

Cardholder Name:

Card Type: ◇ Visa ◇ MasterCard ◇ Discover

Card Number Expiration Date

Name as it appears on card

Address City State Zip Code

Telephone #'s: Home Work Cell

The Dental Practice of: **Lynne S. Gerlach, D.D.S.**

Is authorized to keep my signature on file and to issue a **credit and/or a charge** memo to my credit card for any outstanding balance. After insurance payment and/or correspondence have been received and applied to my account, any balance over **60 days** will be directly applied to the credit card on file. For charges in excess of $500.00 we will notify you by telephone.

Date: ______________________ **Authorized:** ______________________
Responsible Party

Date: ______________________ **Authorized:** ______________________
Witness