Authorized Credit Card Payment Form

I authorize Vicki Borowski, DDS to keep my signature on file and to

charge my credit card for:

☐ Balance of charges not paid by insurance within 30 days:

☐ All visits this year.

☐ Recurring charges (on-going treatments) of $__________every_________from___________
(frequency) (date)

to____________.
(date)

I assign my insurance benefits to the provided listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider. I also understand that I will be notified monthly or whenever charges are going to be put onto this card.

Patient Name

Cardholder Name

Cardholder Address

City State Zip

Credit Card Account Number Security Code Expiration Date

Cardholder Signature Date

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