Credit Card/Debit Card Authorization

D & R Family Dentistry submits to insurance carriers as a convenience to all our patients. At this time we request authorization to balance bill a major credit card or debit card to cover amounts determined by your insurance to be your responsibility. We will alert you by email or by how you request our office to notify your prior to your card being charged.

Upon receipt of an explanation of benefits from your insurance carrier any unpaid portion of your claim will be billed to your credit or debit card. Should insurance pay in full, your account will not be charged.

All credit card/debit card information will remain absolutely confidential and securely stored by **D & R Family Dentistry** data base. **D & R Family Dentistry** will not store any banking account data.

I hereby authorize D &R Family Dentistry to charge any outstanding balance, after insurance company reimbursement or denial, to my credit/debit card. I understand that I will not receive a statement if there is no balance due after processing my credit/debit card for payment.

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Email Address Required (Please Print)

______________________________________ ____________________________

Cardholder's Authorization Signature Date

_____________________________________ ____________ _____________

Credit/Debit Card Number EXP Date CVV #