

# Preauthorization of Payment

I, \_\_\_\_\_ (Payer), authorize Matthew McRae, Jr., DMD., PC, to keep my signature on file and to charge my

VISA    MasterCard

\_\_\_\_\_

Care Credit

\_\_\_\_\_

Other

\_\_\_\_\_

the balance of charges not paid by dental insurance immediately on receipt of dental insurance co-payment or the balance of charges not paid within 30 days of completion of dental treatment and not to exceed \$ \_\_\_\_\_ for  this appointment only    all appointments this year.

Recurring charges for ongoing treatment or completed treatment of \$ \_\_\_\_\_ every  week    month from (date) to (date). I assign my dental insurance benefits to the above-named provider. I understand that this form is valid for 1 year from the date noted below unless I cancel authorization of the provider in writing.

Patient Name:

Cardholder Name:

Cardholder Address:

City, State, and Zip Code:

Credit Card Account #:

Expiration Date:

\_\_\_\_\_  
Cardholder Signature

\_\_\_\_\_  
Date