



**Authorization Agreement for Automatic Withdrawal of Funds**

Responsible Party Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**CREDIT CARD / DEBIT CARD**

Please charge my payment to my (check one)  Visa  MasterCard  American Express  Discover

Credit Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

CVC #(3 digit security number on back of card): \_\_\_\_\_

American Express (4 digit security number on front of card): \_\_\_\_\_

Name on Card: \_\_\_\_\_

Billing Address (If different from above): \_\_\_\_\_  
\_\_\_\_\_

I authorize Dr. McClurg's Smile Center and Transfirst Health Services to charge my credit card with the information provided above. I understand that this authority is in effect until I provide reasonable notification to terminate the authorization.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date for monthly withdrawal:  5th  20th Other: \_\_\_\_\_

**PLEASE PROVIDE PROOF OF CREDIT CARD WHEN SUBMITTING PAPERWORK.**

**FOR OFFICE USE ONLY:**

**MONTHLY PAYMENT**

Date of first payment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date of last payment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Amount of first payment:\$ \_\_\_\_\_ Amount of monthly payment:\$ \_\_\_\_\_

Amount of last payment:\$ \_\_\_\_\_