LETTER OF AUTHORIZATION TO CHARGE CREDIT CARD

Our HealthCare System has gone through many changes. We are happy to submit claims to your insurance company and accept payment from those insurance companies with whom we are out of network. As your provider, We want to continue providing you with excellent care,but in order to do so, it is necessary to ensure reimbursement for our services. Please read the following.

I,____________________, authorize Carroll Gardens Dental Arts, PLLC to charge the following described credit card the amount equal to what my insurance states is my responsibility.

_____ I understand the amount shall not exceed the amount my insurance deems as my responsibility.

_____ I understand I will be sent an email/phone call informing me of the date of my visit, and the amount to be charged to my credit card before charging my card. A receipt will be sent upon request.

_____ I understand that this Credit Card Authorization will only be used in the event my insurance does not pay for any services provided by, Carroll Gardens Dental Arts, PLLC. This may include but is not limited to **Deductibles**, **Co-Insurances**, **Co-Pays**, **No Show Appointments**, **Cancelled Appointments**, **Policy Cancellations** and **Services not covered under my policy**.

_____ I understand that if my credit card is declined and/or does not process the payment, an invoice will be mailed to me with a $15 surcharge added to my balance.

Card Holder's Name on Card: _____________________________
Tel#____________________
Card Holder's Address:___________________________________
Card Type:_____MasterCard _____Visa _____ AMEX _____Discovery
Credit Card Number:_____________________________________ Exp. Date______________
Security
Code:____
Email
Address:____

I fully understand the above authorization and give Carroll Gardens Dental Arts, PLLC consent to charge my credit card listed above.

Signature:____
Print Name:____Date:__________________