CREDIT CARD INFORMATION FORM

If you do not wish to keep a credit card on file you will pay up front and insurance will reimburse you

Patient: _____ Date: _____

Type of Credit Card: □Visa □ MasterCard □Discover □Care Credit

Complete Credit Card #:_____

3 Digit number on back of credit card: _____ Expiration Date: _____

Billing Information:

Cardholder Name (as it appears on card):

_____

Billing Address:

_____

_____

Phone Number: _____

I authorize Isolani Endodontics to charge my credit card for any balance remaining after my insurance has paid its portion, or insurance has not paid their portion within 60 days. I understand (as stated in office financial policy, which I have signed) that all fees given to me are estimates and in the event my insurance company does not cover services rendered at Isolani Endodontics I understand I am still responsible for all charges.

Signed:_____ Date:_____

□ I wish to be notified before any charges are made to my credit card_____

Initials