Credit Card Authorization

Complete only if choosing Option 3 on Financial Form

Date: _____

Name:_____

Credit Card: MC VISA DISCOVER AMEX

Credit Card Number : _____

EXP: _____ CVV Code :_____

I authorize Kelly West, DDS to charge the credit card listed above should any balance remain on my account after my insurance company completes processing my claims**. I understand that my insurance is a contract between myself and my insurance company and that Dr. West's staff is filing the claim as a courtesy to me. I understand that I am fully responsible for all charges on my account regardless of insurance coverage.**

_____

Patient Signature

Attach credit card copy