CREDIT CARD AUTHORIZATION

I authorize the office of Drs. Davis & Nyczepir, Ltd. to charge the following credit card for scheduled orthodontic payments.

PATIENT NAME_____

NAME AS IT APPEARS ON CARD_____

CARD NUMBER_____

EXPIRATION DATE_____

SECURITY CODE (last 3 digits on back)_____

ADDRESS_____
_____

DAYTIME PHONE CONTACT_____
E-MAIL ADDRESS_____

The above account will be charged $_____per month for_____months with the first transaction being_____(please choose the 1st or the 16th of the month)

*Signature*_____*Date*_____