

WEIMAR FAMILY DENTISTRY

Richard K. Weimar, DDS
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VISA / MASTERCARD / DISCOVER AUTHORIZATION FORM

I authorize *Weimar Family Dentistry/Dr. Richard Weimar* to keep my signature on file and to charge my credit card/bank card for:

1. Recurring charges of \$ _____ every _____ days
from _____ to _____.
(date) (date)

2. Balance of charges not paid by insurance for:

- This visit only.
- All visits this year.

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

Patient Name: _____

Cardholder Name: _____

VISA MASTERCARD DISCOVER

Account #: _____ Expiration Date: _____

Cardholder Signature: _____ Date: _____