209 Harvard Street, 2nd Floor
Brookline, Massachusetts 02446

EXPRESS CHECK OUT

MASTERCARD VISA

Pre-Authorized Health Care Form

I herby authorize: **The Center for Pediatric Dental Care,** to keep my signature on file and charge my credit card account selected bellow for the following.

❑ Recurring co-payments for treatment

❑ All treatment costs

I understand this form is valid unless I cancel this authorization by written notice. If I choose to cancel this form, I assume full responsibility for paying my charges in full at the time of service.

_____
Patient Name:

_____
Cardholder Name:

_____ _____ _____ _____
MasterCard Visa Account Number

_____
Last three digits from back of card

Mo_____ Yr_____
Expiration date:

_____
Cardholder's Signature:

_____
Date

Practice Copy

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Patient Copy

Please keep this copy for your records.