Dr. Ashley E. Burns' office will be going paper-less, therefore we will no longer be billing patients or sending out statements.

CREDIT CARD AUTHORIZATION FORM

January 1, 2014

RESPONSIBLE PARTY:

Effective January 1, 2014, I authorize Dr. Ashley Burns to keep my signature on file and charge my:

___VISA___MASTERCARD___CARE CREDIT___AMERICAN EXPRESS___DISCOVER

___I understand that balances not paid by my Insurance Company within 45 days will be charged to my card automatically.

___I also understand that a financial coordinator will administer a courtesy phone call before my card is charged. It is my responsibility to make sure the financial coordinator can contact me during business hours.

___I assign my insurance benefits to Dr. Ashley E. Burns.

___I understand that this form is valid until my card expires and that Dr. Ashley E. Burns' files my dental insurance as a courtesy. I am aware that my card information may be verified at each visit to ensure validation.

_____
Patients Name

_____ _____
Cardholders Name Mailing Address

_____ _____
Cardholders Contact Number Email Address

_____ _____
Credit Card Number Expiration Date

_____ _____
Cardholder Signature Date

___No thank you. I do not authorize Dr. Ashley E. Burns to charge my credit card for unpaid balances. I understand that by not leaving a credit card pre-authorization on file, I will be required to pay in full for all treatment and will be reimbursed directly from my insurance company.

Signature_____ Date_____