

Reising Orthodontics, PC

One Time and/or Automatic Credit Card Billing Authorization Form

Please complete the credit card information section below and sign the form. All requested information is required.

Upon approval, we will automatically bill your credit card for the amount indicated and your total charges will appear on your monthly credit card statement. You may cancel this automatic billing authorization at any time by contacting us.

Customer Information

Patient Name

Payment Information

I authorize Reising Orthodontics, PC to automatically bill the card listed below as specified:

\$ _____
Amount

Frequency

One Time

Start Billing On: ____/____/____

Monthly

End Billing On: ____/____/____

Credit Card Information

Reising Orthodontics, PC accepts the following credit cards: Visa, MasterCard, American Express and Discover.

Credit Card Type

Credit Card Number

Expiration Date

Cardholder's Name (as shown on card)

Cardholder's Zip Code (from credit card billing address)

Customer's Signature

Date

Upon Completion, Please fax to 678.240.4332 or email to: info@reisingorthodontics.com