AUTHORIZATION FORM

***** PLEASE RETURN BEFORE YOUR FIRST PAYMENT *****
PUCCIOORTHODONTICS@GMAIL.COM

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FOR OFFICE USE ONLY	PATIENT #	DATE

Effective date of authorization: ____/____/____

Type of authorization: ☐ New authorization ☐ Change payment amount ☐ Change payment date
☐ Change banking information

Last Name:	First Name:	
Address:		
	State:	Zip:
Email Address:		

MONTHLY PAYMENT: ☐ 1st ☐ 15th

Date for monthly withdrawal (please check one):

Date of first payment ☐ Date of last payment ☐

Amount of monthly payment $____ Amount of last payment $____ Total number of payments____

Credit Card

Please charge my payments to my (check one): ☐ Visa ☐ MasterCard ☐ Discover Card

Credit Card Number:	Expiration Date:

Name on Card:

Billing Address (if different from above)

I authorize the above practice to charge my credit card in accordance with the information above

Signature (as it appears on the credit card): _____ Date:_____