FISHER & ZITTERICH
FAMILY | COSMETIC | IMPLANT
DENTISTRY

Credit Card Authorization Form

Name on card:_____

Billing Address:_____

City: _____ State**:** _____ **Zip:** _____

Email Address: _____@_____

Phone: _____-_____-_____

Card Type: ○ Visa ○ MasterCard ○ Discover ○ Amex ○ Care Credit

Card Number: _____

Exp. Date: ____/_____ **CVV:** _____

I, _____ authorize Fisher & Zitterich Dentistry to process any charges left on my account after insurance reimbursement. I understand I will be given a *one-time courtesy call* to remind me of the balance due. I will have 24 hours to return the call if I wish to change the amount charged.

Signature:_____

Date: _____