



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

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: _____