CREDIT CARD PRE-AUTHORIZATION FORM

In order to simplify the billing process, effective 3/1/2021, Santa Monica Dentistry for Children will no longer be sending out billing statements for outstanding balances on patient accounts. We ask that you provide our office with pre-authorization to apply any outstanding balances due to us, after your insurance has processed and paid their portion of your claims, to your credit card. This includes, but is not limited to, co-pays, co-insurances, deductibles, non-covered charges, and 48-hour cancellation/no-show fees. A receipt detailing any credit card payments that we process will be sent to your email address on file. This new policy does change our office policy of collecting your co-insurance and deductible at the time of your visits. If you insurance overpays what they have quoted to our office at the time of your visit, a refund will be issued to you within 30 days.

I authorize Santa Monica Dentistry for Children to keep my signature on file and to charge my credit card for any portion of a claim for which I am responsible, or which is not paid or covered by my insurance carrier, or for fees for which I am responsible, but have yet to pay.

This information is filed securely along with your other confidential information.

VISA mastercard AMERICAN EXPRESS

Cardholder Name:_____

Credit Card#:_____

Expiration Date:_____/_____

Security Code:_____

Address Associated with Card:_____

Card Holder Signature:_____

Date:_____/_____/_____

If you elect not to sign this form, we will send you a paper statement for any outstanding balances. Any balances not paid in full within 30 days of the statement date will be subject to a monthly interest fee.

*If you do **not** want to leave your credit card on file, please sign here as acknowledgement of the previous paragraph.*

Name:_____ Date:_____/_____/_____