ENDODONTIC SPECIALIST OF BEVERLY

Pre-Authorization Form

I authorize the ENDODONTIC SPECIALIST OF BEVERLY to keep my signature on file and to charge my Visa or MasterCard® account as indicated below:

Charge (*Check One*): ☐ Visa ☐ MasterCard®

For my CO-PAY or FEES:

Charge Date___/___/____ Amount $_____
Charge Date___/___/____ Amount $_____
Charge Date___/___/____ Amount $_____
Charge Date___/___/____ Amount $_____

I assign my insurance benefits to the Endodontic Specialist of Beverly. ***IF MY INSURANCE BENEFIT RUNS OUT*** and I have an outstanding balance I authorize my credit card to be charged (*check one and indicate the days*)

☐ MONTHLY, every _____day of the month

☐ BI-WEEKLY, every (*circle two*) 1st, 2nd, 3rd, 4th Friday

in the **amount** of $_____, until the balance is paid in full.

I understand that this form is valid within the indicated time frames unless I cancel the authorization through written notice to the ENDODONTIC SPECIALIST OF BEVERLY.

_____
Patient Name

_____
Cardholder Name

_____
Cardholder Billing Address

_____
City State Zip

_____Mo_____Yr_____
Account Number Expiration Date

X_____
Cardholder Signature Date

Provider Copy - White **Patient Copy - Yellow**