AUTHORIZATION FOR CREDIT CARD PAYMENTS

I, ____, understand that I have chosen to assign my dental benefits to Jennifer A Sokolosky DMD, PA and a claim form will be sent to my insurance company for treatment provided.

I further realize that I am ultimately responsible for the total fee for services rendered regardless of my insurance company's willingness to pay a benefit. I hereby authorize **Jennifer A Sokolosky DMD, PA** to keep my signature on file and to charge my credit card account for any and all treatment fees not paid by my insurance carrier or myself within 60 days.

____
Cardholder's Name

____
Cardholder's Address

____
Cardholder's Address2

____
Cardholder's Telephone #

☐ MasterCard ☐Visa ☐AMEX ☐Discover

____
Credit Card Account #

______/______ ________
Expiration Date CW2- *3 digit code on the back of your card*

____
Cardholder's Signature

____
Date