OKANAGAN SMILES

CREDIT CARD AUTHORIZATION

I authorize Okanagan Smiles to keep my signature on file and to **charge my Visa or M/C** account for the following reasons:

- Balance of charges not paid by my insurance immediately after receiving payment from insurance company, will be charged. Patients will be notified if the charge is over $100
- All outstanding balances on my family account if not paid within 30 days by my insurance, will be charged
- Charges accrued as a result of broken appointments, will be charged
- Short notice cancellations **less than 48 business hours,** will be charged $100/per hour

Patient Name(s): _____

Cardholder Name: _____

Cardholder Address: _____

_____

Phone Number: (H) _____ (W)_____ (C)_____

Cardholder Signature: _____

Date: _____

Credit Card Information:

Card Number: _____ Exp Date: _____/_____
MM YY

Verification Code: _____ (last 3 digits on back of card)