 CREDIT CARD INFORMATION FORM

*If you do not wish to keep a credit card on file you will pay your balance in full and insurance will reimburse you*

As it has become the standard in medical practices, Isolani Endodontics has implemented a credit card policy to help minimize health care cost for both our patients and office. Your credit card number and information is held **SECURELY.**  Once insurance has paid their portion, ***if your balance owed is $100 or less your card on file will automatically be charged***. If your balance exceeds $100 your credit card on file **will be charged $100** and we will contact you with the remaining balance owed.

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Credit Card: □Visa □ MasterCard □Discover □Care Credit

Complete Credit Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 Digit number on back of credit card: \_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_

**Billing Information**:   
Cardholder Name (as it appears on card): Phone Number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Our office will email you a receipt with the amount charged to the card on file)

I authorize Isolani Endodontics to charge my credit card for any balance remaining of $100 or less after my insurance has paid its portion, or insurance has not paid their portion within 60 days. I understand (as stated in office financial policy, which I have signed) that all fees given to me are estimates and in the event my insurance company does not cover services rendered at Isolani Endodontics I understand I am still responsible for all charges. I understand if I do not contact Isolani Endodontic regarding remaining balance, $100 will be charged to my card every month until the balance is paid in full.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_