PLEASE BRING THE CREDIT CARD AUTHORIZATION FORM TO THE OFFICE

ORTHODONTICS *of* ATLANTA
Your Smile is our Specialty!

Permission for automatically charge on MasterCard VISA AMERICAN EXPRESS DISCOVER

Date: _____

Patient's Name:_____**Patient #**_____

I give my permission for ORTHODONTICS *of* ATLANTA Your Smile is our Specialty! **to automatically post the orthodontic treatment charge to my credit card on a monthly basis.**

Card Number:_____

Credit Card:_____

Expiration Date:_____**CVV Code**_____

Name in Card:_____

Monthly Amount: $_____**Date to Start:**_____

Signature:_____

FOR THE OFFICE STAFF USE ONLY. DO NOT FILL OUT ANY INFOMATION BELOW

JAN_____	JAN_____	JAN_____
FEB_____	FEB_____	FEB_____
MARCH_____	MARCH_____	MARCH_____
APRIL_____	APRIL_____	APRIL_____
MAY_____	MAY_____	MAY_____
JUNE_____	JUNE_____	JUNE_____
JULY_____	JULY_____	JULY_____
AUG_____	AUG_____	AUG_____
SEP_____	SEP_____	SEP_____
OCT_____	OCT_____	OCT_____
NOV_____	NOV_____	NOV_____
DEC_____	DEC_____	DEC_____

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