Visa/MasterCard/Amex Authorization for Monthly Payments

I, _____ (cardholder), hereby authorize William B. Miller, DMD to charge my Visa/MasterCard credit/debit card for my monthly payments for orthodontic services provided to _____ (patient's name). I hereby authorize William B. Miller, DMD to accept and post these transactions to my account.

This authorization will remain in effect until I provide written notice to William B. Miller, DMD requesting termination. Notice of cancellation will require at least five (5) business days to act on the cancellation.

Visa or MasterCard or American Express (circle one) Account #: _____

Billing address: _____ Zip code: _____

Phone number: _____

Expiration Date: _____

Name on Card: _____

Signature of Card Holder: _____

****Office use ONLY ****

Patient's Name: _____ Patient's Account #: _____

Date Braces Placed: _____ Monthly Charge: $_____

Number of Monthly Payments: _____ Month to Begin Payments: _____

DAY of Month to Begin: (circle one) 1st 10th 15th 25th

Month	Date Paid	Month	Date Paid	Month	Date Paid
January		January		January	
February		February		February	
March		March		March	
April		April		April	
May		May		May	
June		June		June	
July		July		July	
August		August		August	
September		September		September	
October		October		October	
November		November		November	
December		December		December	