Orthodontic Associates of Port Huron

Dr. George Ash, DDS, MS

Orthodontics for Children and Adults

Payment Consent Form for Visa, MasterCard and Discover

I authorize Dr. George Ash to keep my signature on file and to charge my credit card for:

- Recurring charges of $_____ every month from _____ to _____ or until treatment ends.
- Payment will be charged on or after the _____ day of the month.
- Any payment not received within 30 days of the due date in the amount of $_____. Interest will be added to your past due amount at the rate of 18% per annum as stated in your contract.
- There will be up to three attempts to authorize the payment on successive business days if the charge card is declined payment on the date agreed upon.
- There will be up to three attempts to authorize payment on successive business days if the charge card payment has been declined on the date agreed upon.

Cardholder Information (a copy of the credit card is also required)

Patient Name: _____

Patient Number: _____

Cardholder Name: _____

Cardholder Address: _____

_____

Phone Number: _____

Visa ___ MasterCard ___ Discover ___ Expiration Date:*_____

Account Number: _____

Cardholder Signature: _____

Date of Signature: _____ Witness: _____

* It will be your responsibility to provide us with your current card information should your card expire or change.