

CREDIT CARD AUTHORIZATION FORM

I, _____, hereby authorize Boulder Valley Dental Center to submit electronic claims on my behalf and agree to assign the payment directly to Boulder Valley Dental Center. I understand that my dental benefit reimbursement plan is an agreement between my insurance company and myself. I further understand that I am responsible for any service fees or balances that may not be covered by my dental benefit plan and any differences resulting from the amount billed, including estimated copayments already collected, and the amount covered by my plan. I authorize Boulder Valley Dental Center to debit my credit card account for payment of any account balance remaining once the insurance check is posted to my account. If insurance payment is delayed longer than 30 days, I authorize Boulder Valley Dental Center to debit my credit card account for any remaining balance on my account not paid by my insurance company.

PATIENT NAME

DATE

SIGNATURE

PHONE #

RESPONSIBLE PARTY NAME

ZIP CODE

Please circle credit card: **MasterCard** **Visa** **Discover** **American Express**

_____-_____-_____-_____
CARD #

_____/_____
EXP. DATE

CC SECURITY CODE

CARDHOLDER SIGNATURE

DATE

PRINT NAME

BVDC INITIALS