CREDIT CARD PREAUTHORIZATION

Epstein & Rapoport, P.C.

345 North Main Street	6 Airport Road	101 Main Street
West Hartford, CT	North Windham, CT	Unionville, CT
06117	06256	06085
860-523-4213	860-456-0506	860-673-3900

Patients name (s)_____

_____

I authorize Epstein & Rapoport, P.C. to charge my credit card account for:

☐ Any balance remaining after my insurance has paid the benefits available in my plan or after a period of 60 days from the date of treatment if my insurance company has not responded to the submittal for any treatment.

☐ A monthly payment of $_____ per month for _____ months for dental treatment planned on _____.

☐ Master Card ☐ Visa ☐ Discover

Credit Card # _____

Exp. date _____ Cardholder name _____

Cardholder signature _____

Billing address _____

_____