Patient/Guarantor - Credit Card Authorization

- I authorize Avon Dental to keep my signature on file and to charge the following credit card for any outstanding account balances on my personal patient account or immediate family member's account. It is my responsibility to ensure this information is always current and up to date.

- It is my responsibility to contact Avon Dental to arrange an approved, alternate payment method, in advance of the timelines and payment schedule listed below:

Initial_____

Patients with Dental Insurance:

- Avon Dental will submit the insurance claim on my behalf, and I understand that the *estimated* patient portion of my visit will be collected at the time of service.
- Once the insurance claim has been processed and the payment has been received:
    - I authorize Avon Dental to run my card on file for any balance $50 or less, per family member.
      Note: There is a 3% surcharge applied to all transactions which is no greater than our cost of accepting credit cards
    - For a balance $51 or greater, I will receive a statement by email and/or a text notification that insurance has paid and there is a balance on the account, greater than $50.
    - I have 30 days to pay that balance in full by any payment method I choose.
    - If 30 days have passed and the balance has not been paid in full and I have not contacted the office to arrange an alternate payment, I authorize Avon Dental to run my full balance on the card on file, authorized on this form.

Patients – Cash Pay or Loyalty Member Program:

- Payment is due in full, at the time of service. I authorize Avon Dental to run my card on file for any remaining balances that are $50 or less.
- For any balances $51 or greater, I will receive a statement by email and/or a text notification that there is a balance on the account, greater than $50. I have 30 days to pay that balance in full.
- If 30 days have passed and the balance has not been paid in full and I have not contacted the office to arrange an alternate payment, I authorize Avon Dental to run my full balance on the card on file, authorized on this form.

Initial_____

AVON
DENTAL

PATIENT Credit Card Payment Authorization Form

Patient Full Name: _____

Patient Phone Number: _____

Patient Billing/Mailing Address: _____

_____

Credit Card: (circle) MasterCard / Visa / AMEX / Discover / Care Credit

Name (as it appears) on Card: _____

Card Number: _____

Expiration Date: _____ CVC Code: _____

Card Zip Code: _____

By signing this form, I authorize Avon Dental to keep my signature on file and to run outstanding account balances for myself and immediate family members as outlined in their Financial Policy.

Note: There is a 3% surcharge applied to all transactions which is no greater than our cost of accepting credit cards

Cardholder signature: _____Date: _____

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GUARANTOR Credit Card Payment Authorization Form

Guarantor Full Name: _____

Guarantor Phone Number: _____

Guarantor Billing/Mailing Address: _____

_____

Credit Card: (circle) MasterCard / Visa / AMEX / Discover / Care Credit

Name (as it appears) on Card: _____

Card Number: _____

Expiration Date: _____ CVC Code: _____

Card Zip Code: _____

By signing this form, I authorize Avon Dental to keep my signature on file and to run outstanding account balances for my children/dependents 18 years and younger and other immediate family members as outlined in their Financial Policy.

Note: There is a 3% surcharge applied to all transactions which is no greater than our cost of accepting credit cards

Cardholder signature: _____Date: _____