Dr. Michael Lacey
Authorization form to bill Credit Card

Treatment balance $_____

This form of authorization gives permission to Dr. Michael Lacey, DMD to charge and bill the credit card listed below the amount indicated above. This form is to be used for charges that are to be made or that have already been made to the card listed above for dental treatment.

I, the undersigned cardholder, hereby authorize(d) the following charges in the amount of _____ to my Credit Card to be billed monthly for ____ months or until the balance is cleared. This card will be billed on the _____ day of the month.

By signing below, I acknowledge that I am the cardholder under penalty of the law and authorize the charges by Dr. Michael Lacey, DMD

Visa Mastercard American Express Discover

Credit Card Number _____

Credit Card Expiration Date _____/_____

Printed Full name of Card Holder as it appears on the card

_____

Card holders Telephone # as listed with the bank: (_____) - _____-_____

Signature to Authorize Card:

_____

Credit card CSC Code _____

Billing Address as it appears on the cardholder's monthly statement:

Street:_____

City:_____State_____Zip_____

Failure to have available credit for billing as agreed will result in a payment penalty of $50 for each billing cycle in which the credit is denied.