HOLT FAMILY DENTISTRY

Sheila Gordon-Holt, D.D.S., P.A.

Credit Card Authorization Form

I _____ hereby give Holt Family Dentistry (Dr. Sheila Gordon-Holt, DDS P.A.) authorization to charge my credit card below. This form will be my signature on file until I submit in writing by certified mail to terminate agreement.

I understand that any charge for deposit on treatment or to secure appointment to my credit card on file will not be refunded if I miss or cancel appointment without required 48 hour notice weekends or holidays do not count as working days. **Initial:_____.**

I understand that Holt Family Dentistry can apply additional $50.00 fee for decline on credit card on file if unable to get payment for services or deposits. **Initial:_____.**

Please list any other family member that Holt Family Dentistry can use your credit card on file for payments or deposits:

_____

_____

Cardholder Name:_____

Card Number:_____

Card Type: Visa☐ MasterCard☐ American Express☐ Discover☐ Care Credit☐

Expiration Date:_____

Security Code:_____ (3 digit code on back or AMEX 4 digits front)

Billing Zip Code:_____

I understand all of the above and give Holt Family Dentistry the authorization to keep above credit card on file.

Card Holder Signature:_____

Date:_____

12105 Copper Way, Suite 200 • Charlotte, NC 28277 • Telephone: (704) 542-2325 • Fax: (704) 542-0920
www.holtfamilydentistry.com