**Patient/Guarantor - Credit Card Authorization**

* I authorize Castle Peak 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 Castle Peak Dental to arrange an approved, alternate payment method, in advance of the timelines and payment schedule listed below:

**Initial\_\_\_\_\_\_**

**Patients with Dental Insurance:**

* Castle Peak 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 processed and the payment has been received:
  + I authorize Castle Peak Dental to run my card on file for any balance $50 or less, per family member.
  + 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 Castle Peak 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 Castle Peak 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 Castle Peak Dental to run my full balance on the card on file, authorized on this form.

**Initial\_\_\_\_\_\_**

**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 Castle Peak Dental, LLC to keep my signature on file and to run outstanding account balances for myself and immediate family members as outlined in their Financial Policy.

Cardholder signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 Castle Peak Dental, LLC 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.

Cardholder signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_