Financial Agreement Pre-Authorization Form

☐ I accept attached payment agreement established with the office of Dr. Chad Burtless-Creps per my signature below:

Patient Signature: _____Printed Name: _____

Date: _____

I agree to pay the office of Dr. Chad Burtless-Creps $ _____ per month as agreed per attached payment amortization schedule. I agree to notify the office of Dr. Chad Burtless-Creps if I am able to increase the amount of monthly payments.

Received in office: _____
Staff Initials: _____

☐ I authorize the office of Dr. Chad Burtless-Creps to charge my credit card as detailed below:

ONE-TIME AUTHORIZATION

☐ Please cover any unpaid balance after insurance payment only for this current treatment not to exceed $ _____ (visit total).

CONTINUOUS AUTHORIZATION

☐ Please keep this signature on file to cover any unpaid balance after insurance payment for any treatment performed in this office.

CREDIT CARD:

☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Card #:_____ Expiration Date: _____ Security Code: _____

Cardholder Signature: _____

Printed Name: _____

Staff Initials: _____ Date: _____

☐ Copy to Patient, file original in chart.