NJ Center for Oral Surgery

16 Smull Avenue, Caldwell, NJ 07006
256 Columbia Turnpike, Florham Park, NJ 07932
Fax (973) 226-7876
info@njcenteros.com

Debit/Credit Card Authorization Form

I authorize the **NJ Center for Oral Surgery** to charge a $200 deposit to reserve a surgical appointment for _____.

Name on Credit Card (if different from patient named above): _____

Credit Card Billing Address for Credit Card (if different from patient named above):

_____

Circle one: Visa MasterCard Debit Discover American Express

Card Number: _____

Exp. Date (Mo/Yr):_____

The above credit card will NOT be charged until the scheduled appointment time as per the Financial Policy.

This signed form will be kept on file at the NJ Center for Oral Surgery. A copy of this form maintains the same authorization as the original.

You are giving your permission to automatically charge your credit card according to the terms of the Financial Policy and any payment agreements for any unpaid balance.

Authorized Agent certifies warrants and represents that the cardholder named above agrees to pay the credit charge(s) in accordance with the Card Issuer Agreement.

Cardholder/Authorized User Signature _____ Date_____