Credit Card Payment Authorization Form

As part of our financial agreement for uninsured services, we ask to keep a credit card on file for your account.

Please sign and complete this form to authorize **Preston Smiles** to charge my credit card for any balances on my account to information listed below. I will also receive a statement in the mail regarding my account information.

Please complete the information below:

I ______________________________ authorize **Preston Smiles** to charge my credit card

(full name)

account indicated below for ______________ (amount)

- ○ Please call before processing any transactions
- ○ Please go ahead and charge any balance that may accrue.

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name ____

Account Number ____

Expiration Date ____________

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _______

SIGNATURE ____ DATE ____________________