EXPRESS CREDIT CARD CHECKOUT FORM

I ________________________________ authorize Highland Dental Clinic to keep my signature on file, and to bill my credit card for the balance of my dental visit not covered and/or paid by my insurance. I will be notified by phone if any charge is in excess of $200.00. A receipt of all transactions will be mailed with a paid statement.

Payment by:_____Visa _____ Mastercard_______American Express:

Card Number Expiry Date Verification Code

Name on Card Signature of Card Holder

Please list all other family members for whom you are financially responsible:

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