

# Jeffrey D. Bert, D.D.S., M.D.Sc., P.C.

## Practice Limited to Orthodontics

561 Saybrook Road, Middletown, Connecticut 06457  
Telephone (860) 347-8004  
Fax (860) 346-9131

### Credit Card Authorization Form

#### Patient Information

Patient Name: \_\_\_\_\_ Account#: \_\_\_\_\_

Responsible  
Party Name: \_\_\_\_\_

Responsible  
Party Address: \_\_\_\_\_

#### Payment Information

Cardholder  
Name: \_\_\_\_\_

Card Number: \_\_\_\_\_

Exp date: \_\_\_\_\_ V-code: \_\_\_\_\_

Amex Discover

Billing Address: \_\_\_\_\_

MasterCard Visa

Would you like a receipt? Yes \_\_\_ No \_\_\_

Payment entered on the 1<sup>st</sup> \_\_\_\_\_ or 15<sup>th</sup> \_\_\_\_\_ of month

#### Signature

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize Jeffrey D Bert, D.D.S., M.D.Sc. P.C. to keep my signature on file and to charge my credit card account as indicated above. This authority will remain in effect until Jeffrey D Bert, D.D.S., M.D.Sc., P.C. is notified by me in writing to cancel it in such time as to afford Jeffrey D Bert, D.D.S., M.D.Sc. P.C. and my financial institution a reasonable opportunity to act on it, or until the balance is paid in full.

For office use only: Entered \_\_\_\_\_ Last payment date \_\_\_\_\_

Please mail or fax form to:  
Jeffrey D. Bert, D.D.S., M.D.Sc., P.C. 561 Saybrook Rd., Middletown, CT 06457  
Fax: (860) 346-9131