



Petaluma Valley Dental

Insurance Credit Card Authorization Form

Print Name: _____

Phone Number: _____

Email: _____

Credit Card Type (Check One): Visa MasterCard American Express

Credit Card Number: _____

Security Code: _____

Expiration Date: _____

Credit Card Holder's Name(print): _____
(exactly as it appears on the credit card)

Billing Address: _____

City: _____ State: _____ Zip: _____

Card Holder Phone Number: (_____) _____ - _____

I understand the insurance quotes given are only an estimate.
Actual charges and covered benefits are only determined once the Explanation of Benefits from the insurance company is received. As a result my account may have a balance and I am responsible for settling my balance.

I authorize Petaluma Valley Dental to charge the above card for any outstanding balances, due to insurance coverage differences up to:

\$500 \$250 \$100 Other: _____ (please check one)

If the balance exceeds the amount checked above, please contact me first via
____phone or ____email before processing payment. Once payment is processed-

Please Email Mail Do Not Send **me a copy** .

(of) Receipt EOB Both

Signature

Date