Adam J. Frieder, DDS, LLC
Frederick Dental
Family and Cosmetic Dentistry

Credit Card Payment Authorization Form

Sign and complete this form to authorize Adam J. Frieder, DDS, to make a debit to your credit card listed below.

Please complete the information below:

I authorize the office of Adam J. Frieder, DDS, to charge the balance due after the insurance carrier has paid their portion of the claim for dental work rendered.

Patient: _____ **Date:** _____

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX

Cardholder Name _____

Account Number _____

Expiration Date _____

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

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.