



CREDIT/ DEBIT CARD AUTHORIZATION FORM

I HEREBY AUTHORIZE HASHEM ORTHODONTICS TO KEEP MY SIGNATURE ON FILE AND TO CHARGE

MY _____ ACCOUNT FOR A RECURRING MONTHLY CHARGE
(Debit Card, VISA, MASTERCARD, DISCOVER, AMEX)

OF \$ _____ FROM _____ TO _____, ON OR ABOUT THE [] 1st or [] 15th OF EACH MONTH.
(MONTH/ YEAR) (MONTH/ YEAR)

I UNDERSTAND THAT THIS FORM IS VALID UNTIL ALL THE TREATMENT CHARGES HAVE BEEN PAID FOR OR UNLESS I CANCEL THROUGH WRITTEN NOTICE TO HASHEM ORTHODONTICS.

PATIENT NAME

CARDHOLDER NAME

CARD NUMBER

EXP. DATE

SECURITY CODE

BILLING ZIP CODE

CARDHOLDER SIGNATURE

DATE

Hashem Orthodontics
5001 Heritage Ave | Colleyville | t 817.283.3000 | f 817.283.3010
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HashemOrthodontics.com
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