Tsintolas ORTHODONTICS

Chris E Tsintolas, DDS, MS
Specialist in Orthodontics & Dentofacial Orthopedics

AUTHORIZATION FOR RECURRING CREDIT CARD PAYMENT SERVICE for ______________________

[patient name]

AUTHORIZATION STATEMENT

I hereby authorize Chris E. Tsintolas, D.D.S, M.S., herein referred to as the Practice, to process recurring charges to my credit card, and, if necessary, initiate adjustments for any transactions credited/debited in error. The card I offer is one in which funds are reliably available to the Practice.

PAYMENT DATE

I direct the Practice to charge my credit card on the first day of each consecutive month, according to the payment schedule stipulated in the Contract, a separate document. On occasion, due to a holiday, vacation, equipment/software failure, or unforeseen incident the Practice may be unable to charge the card on the first of the month. In such instances, I direct the Practice to charge my card on the first day it can do so.

PAYMENT AMOUNT

I direct the Practice to charge to my credit card the monthly fee, stipulated in the Contract. Should the amount due on the first of the month differ from the monthly fee, I permit the Practice to charge the amount due rather than the monthly fee.

TERMINATION OF THIS AUTHORIZATION

This Authorization remains in effect until one of the following events occurs:
(1) .....The account is paid in full, at which time this Authorization terminates.
(2) .....The Practice receives my written request to terminate this Authorization.
(3) .....The credit card expires, at which time this Authorization terminates.
(4) .....I terminate this Authorization and replace it with another Authorization.
(5) .....The Practice terminates this Authorization.
Additional details follow in the corresponding numbered sections below.

PAID IN FULL ACCOUNT (1)

This Authorization immediately terminates when the account is paid in full ($0.00 account balance). No action is required by the cardholder.

TERMINATION BY THE CARDHOLDER (2)

At any time, I may elect to terminate this Authorization and I shall do so in writing. I shall provide adequate notice to afford the Practice a reasonable opportunity to act. I recognize that the Practice cannot accept verbal cancellations of this Authorization. (See PROCESSED TRANSACTIONS ARE NON-REVERSIBLE and UNCOLLECTED FUNDS.)

EXPIRED CARDS (3)

This Authorization automatically terminates upon the expiration of the credit card. If I wish to continue with the recurring credit card payment service, it is my responsibility to request and complete a new Authorization and I shall indicate "Yes" at the prompt to terminate use of the card currently on file. I shall return the Authorization with adequate notice to afford the Practice a reasonable opportunity to act; otherwise, in the meantime, I will remit payments on time and by other means. If I fail to act, I convey my wish to stop participation in the recurring credit card payment service upon the card's expiration. Expired cards cannot be processed for payment. I recognize that the Practice cannot accept verbal updates to my credit card information. (See UNCOLLECTED FUNDS.)

REPLACE THIS AUTHORIZATION WITH ANOTHER (4)

Should I wish to pay with a credit card different from the one specified on this Authorization, I shall request and complete an Authorization for the new card and I shall indicate "Yes" at the prompt to terminate use of the card currently on file. I shall provide adequate notice to afford the Practice a reasonable opportunity to act. (See PROCESSED TRANSACTIONS ARE NON-REVERSIBLE.)

TERMINATION BY THE PRACTICE (5)

If my credit card is repeatedly declined, I understand the Practice reserves the right to terminate this Authorization and refuse re-enrollment in the recurring credit card payment service. If I wish to pay with a credit card, I acknowledge the Practice may elect only to do so with a card swipe transaction executed in the office. (See UNCOLLECTED FUNDS.)

The Practice extends to me the recurring credit card payment service as a convenience in remitting my orthodontic fees and, as such, I understand that the Practice reserves the right to terminate this Authorization at any time. The Practice will notify me of termination.

UNCOLLECTED FUNDS

The Practice will notify me if my credit card is declined and I understand that I am responsible to immediately remit the full amount due. If my card is expired and/or this Authorization is terminated, I am responsible to remit the full amount owed when due and on time. I understand that if a balance remains unpaid, a statement is generated and the account is subject to billing fees, as described in the Contract.

PROOF OF PAYMENT AND RECEIPTS

Proof of payment is my financial institution's record of the charges made by this Practice. The office will also send a receipt to the financial e-mail of record.

PROCESSED TRANSACTIONS ARE NON-REVERSIBLE

I shall not request the Practice reverse processed transactions. I shall not request the Practice reverse a processed transaction to facilitate remittance with a different card or other payment method. Processing errors by the Practice are subject to correction.

DISPUTES

I certify that I shall not dispute with my credit card issuer the recurring payment transactions processed by the Practice per my direction, provided the transactions correspond to the terms of this Authorization and the Contract.

CARDHOLDER DECLARATION

I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this recurring payment agreement with the Practice.

INSTRUCTIONS

Please complete one Authorization and return by mail or fax. Please retain a second copy for your records and future reference.

____
Name of **CARDHOLDER** (Please print exactly as it appears on card.)

____
Relationship of **CARDHOLDER** to Patient

____
CARDHOLDER'S Address of Record with Card Issuer (Street, Unit Number, City, State, Zip)

Please terminate use of the card/card details currently on file and begin charging the card documented on this form.
Check ONE box: ☐ Yes OR ☐ Not Applicable- No Card on File

☐Visa ☐MC ☐Discover XXXX – XXXX – XXXX – __________ Last Four Digits of Card #

__________ Exp. Date (MMYY)

CARDHOLDER
Write entire card number here ➔➔➔➔

✳✳✳**CARDHOLDER**:
Clearly write your credit card number on lines below.

____ ____ ____ ____ –
____ ____ ____ ____ –
____ ____ ____ ____ –
____ ____ ____ ____

____
I have read and agree to all terms above. Signature of Cardholder

____
Date

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