Tsintolas ORTHODONTICS

Chris E Tsintolas, DDS, MS

Specialist in Orthodontics & Dentofacial Orthopedics

Fellow of the American College of Dentists

AUTHORIZATION FOR RECURRING CREDIT CARD PAYMENTS for _____

patient name- ONE patient per Authorization form

Chris E. Tsintolas, DDS, MS (the Practice) offers the Financially Responsible Party (FRP) two options for payment of the treatment fee: (1) payment in full before treatment begins or (2) an interest-free payment plan. An Authorization for Recurring Credit Card Payments (Authorization) is required for payment plans. Through an Authorization, the FRP presents to the Practice an active, reliable credit card from which the Practice draws recurring payments. The Practice accepts Visa, Mastercard, and Discover (credit card).

Should the Practice change credit card processors, the FRP will cooperate with the Practice and its process for onboarding credit card details to the new processor's system.

CARDHOLDER AUTHORIZATION

The cardholder authorizes the Practice to draw recurring payments from the credit card provided on this Authorization:

- no earlier than the day the payment is due, and
- for the amount due rather than the scheduled fee if the amounts differ.

AN AUTHORIZATION IS REQUIRED FOR PAYMENT PLANS

An Authorization is required for patient accounts with a payment plan. Over the course of the payment plan, the FRP may find it necessary to change/update the credit card from which the Practice draws payment. In good faith, the FRP shall proactively submit Authorizations to the Practice for each change/update for receipt by the **DEADLINE**, ensuring uninterrupted remittance on the patient account. The Practice reserves the right to require the FRP to submit an Authorization for a different credit card. Should the FRP fail to cooperate with the terms of the payment plan and/or Authorization, the Practice reserves the right to cancel the payment plan and compel payment of the account balance.

AUTHORIZATION EFFECTIVE PERIOD

This Authorization remains in effect until it is replaced with another Authorization, the patient account is paid in full, or the Practice cancels the payment plan and compels payment of the account balance. The FRP may elect to pay the account balance in full at any time without penalty and, in doing so, terminate this Authorization.

BALANCE DUE

The FRP will be notified if the authorized card is unavailable for payment on the first of the month. The FRP must remit the balance due the same day, on the first of the month, via the Patient Portal. Otherwise, the Practice reserves the right to cancel the payment plan and compel payment of the account balance. See **PAYMENT METHODS**. Refer to the **CONTRACT FOR ORTHODONTIC TREATMENT**.

ALTERNATE PAYMENT- OPTIONAL

For any or all scheduled fees, the Practice accepts **PAYMENT METHODS** in place of payment with the authorized credit card if payment is received by the **DEADLINE** and the payment results in $0.00 due on the first of the month. Otherwise, the authorized card will be processed for payment as scheduled. Remittance with alternate payments does not waive **AN AUTHORIZATION IS REQUIRED FOR PAYMENT PLANS**.

PAYMENT METHODS

Payment methods for a **BALANCE DUE** or an **ALTERNATE PAYMENT**:

- Visa, Mastercard, and Discover online payments through our Patient Portal
- checks payable to Chris E. Tsintolas, DDS, MS (**ALTERNATE PAYMENT** only)

DEADLINE

Recurring payments is an automated process. The Practice must receive a new Authorization or an **ALTERNATE PAYMENT** before the Practice closes on our last business day of the month. Otherwise, the Practice does not have adequate time to act and the authorized card of record will be processed for payment as scheduled.

FSA, HSA, OR OTHER FUNDED PAYMENT ACCOUNT

The payment plan is not modified and payments are not forgiven or postponed when the authorized credit card is an FSA, HSA, or other funded account. The FRP shall remit in advance with an **ALTERNATE PAYMENT** when underfunding is anticipated. If the credit card remains underfunded, an Authorization for a different credit card is required. The Practice reserves the right to require the FRP to submit an Authorization for a different credit card.

TRANSACTIONS ARE NON-REVERSIBLE

Transactions processed to the authorized credit card will not be reversed, including to "re-pay" with a different payment method. See **CORRECTIONS AND DISPUTES**.

CORRECTIONS AND DISPUTES

The cardholder allows the Practice to correct its errors or system errors. The FRP is liable for fees assessed to the Practice should the cardholder dispute transaction(s) with the card issuer and/or ask the card issuer to correct errors. See **TRANSACTIONS ARE NON-REVERSIBLE**.

VERBAL UPDATES TO CREDIT CARD INFORMATION

The Practice cannot accept verbal updates to credit card information- including updates to the expiration date. Please submit updates with an Authorization.

PROOF OF PAYMENT

Proof of payment for recurring credit card payments:

- the cardholder's financial institution's record of payments to the Practice
- the emailed payment receipt from the Practice to the FRP
- the Patient Portal financial records, available to the FRP to view and print

WHERE TO FIND AUTHORIZATION FORMS

Visit our website, www.DrTOrthodontics.com. Navigate to the Patient Forms page. Scroll down to the Credit Card Authorization, click the button, and print the form.

INSTRUCTIONS

Provide ALL requested information and sign as directed. Submit the full page to the Practice by USPS mail or fax (see footer). Retain a copy for your records. For your protection, the credit card brands do not permit transmission of credit card information over the internet.

This Authorization replaces prior Authorizations for this patient account. Signatures represent acceptance of Authorization terms.

_____ _____

CARDHOLDER name as it appears on credit card | **CARDHOLDER** relationship to patient

_____

CARDHOLDER address on record with card issuer: street, unit #, city, state, zip

The authorized card is:

☐ Visa ☐ MC ☐ Discover XXXX – XXXX – XXXX – _____ _____ /

last 4 digits of card | expiration date: MM/YY

_____ _____ _____

CARDHOLDER signature | date | **CARDHOLDER** Phone #

****** CARDHOLDER ******
legibly write the authorized card number ↓↓ on the lines below ↓↓

******** → CARDHOLDER → legibly write → authorized → credit card → number here → ********

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

FINANCIALLY RESPONSIBLE PARTY signature *if the **CARDHOLDER** is not a **FINANCIALLY RESPONSIBLE PARTY*** _____ date

******** CARDHOLDER- specify ↓↓↓**

effective ☐ today or on _____ date

Tsintolas_Authorization Credit Card_20220401.docx, © Copyright Chris E. Tsintolas, D.D.S., M.S./D. G. Tsintolas, D.D.S., 2005- 2018, 2021- 2023. All rights reserved.