Masha Kogan, DDS

CREDIT CARD AUTHORIZATION FORM

I _____ hereby authorize the Dental Center of Westport to submit electronic claims on my behalf and agree to assign the payments directly to the Dental Center of Westport. I understand that my insurance is an agreement between the insurance company and myself. I further understand that I am responsible for any service fees or balances that may not be covered by my dental benefits plan and any differences resulting from the amount billed and the amount covered by my plan.

Signature: _____Date: _____

Patient Name: _____

Responsible Party (if different from patient): _____

I authorize the following credit card to be billed for any outstanding balances. I further authorize this card to be charged a "no show" fee of $75 per hour, if I fail to show or cancel my appointments without giving at least 24-hour notice.

☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Card number: _____

Expiration date:_____

Security code: _____

Phone number:_____

Cardholder name (please print): _____

Cardholder signature: _____Date: _____

Staff initials: _____

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