Westfield Pediatric

Dental Group

Timothy P. McCabe, D.M.D. Board Certified In Pediatric Dentistry | Julie Jong, D.M.D. Board Certified In Pediatric Dentistry | John Chang, D.D.S. Board Certified In Pediatric Dentistry | Kelly Walk, D.D.S. Board Certified In Pediatric Dentistry | Sara Karlin, D.D.S. Board Certified In Pediatric Dentistry

Authorization to Charge Credit or Debit Card for Services Rendered

I, ______________________, give permission for ***Westfield Pediatric Dental Group*** to charge my credit
(Name)
card for services rendered at Westfield Pediatric Dental Group.

Your credit card will only be charged if your insurance does not cover 100% of the treatment rendered.

If you have no dental insurance your credit card will be charged for all services rendered.

You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier.

____American Express

____Discover

____MasterCard

____Visa

Account Number: ______________________________________

Expiration Date: ________/_______

Security Code (CVC):_________ (3 digit code)

First Name: ______________________ Last Name: ____________________

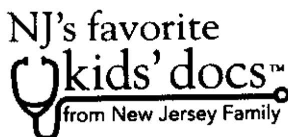
Address: __________________________

City: ______________ State: ______ Zip Code: _________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the WPDG in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day.

AUTHORIZED SIGNATURE __________________________ **DATE** ____________

Authorization to Charge CC/JM/dr2/20



NJ Top Dentists
A Division of NJ Top Docs

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