Gregory E. Elliott DDS
Your Ultimate Smile, Realized.
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:::Credit Card Authorization Form:::

::: Information :::

- Cardholder Name: _____
- Billing Address: _____

  _____
- Credit Card Type: _____Visa _____MasterCard _____Discover _____American Express
- Complete Credit Card Number: _____
- Expiration Date: _____
- Email Address: _____
- By signing this form you acknowledge the following:
  - I allow Dr. Elliott's office to charge the remaining balance from each visit to the card listed above
  - I accept the charge(s) and I agree that I will pay for the charge(s) in accordance with my issuing bank-cardholder agreement
  - I understand the email listed above is for receipt use only and will not be sold, borrowed, or used for any other purpose
  - I acknowledge that I have been given a copy of the privacy statement and accept the terms and conditions set forth by the PCI Security Council
  - I understand that the credit card on file will be stored under the PCI Security Council guidelines
- Please read and retain a copy of the privacy policy for your records.

Print Name: _____

Signature: _____ Date: _____

Authorization: _____ Date: _____