

McDonough Family Dental
32932 Pacific Coast Hwy #19
Dana Point, CA 92629
Phone: (949) 487-7779

Pre-Authorization Agreement for Card on File

I guarantee that I am the legal cardholder for this credit card and that I am legally authorized to enter into this billing agreement. I hereby authorize McDonough Family Dental to keep my credit card information on file to pay my remaining balances for amounts not covered by insurance or remaining balances for procedures I have authorized. I understand that I am responsible for contacting McDonough Family Dental regarding any request to remove a card-on-file (COF) billing account at least ten (10) days prior to an expected or scheduled billing date.

McDonough Family Dental maintains the right to, if necessary, initiate adjustments for any transactions credited/debited in error. Should cardholder wish to amend or cancel card on file detailed below, they must understand that they are still liable for balance owed for services/products rendered.

I understand that, after insurance has paid their portion of my balance, the financial policy of McDonough Family Dental is as follows:

- If the patient has waived the option to be contacted (see below), the COF will be run for the remaining charges on the account, and the patient will receive an emailed receipt.
- If the patient opts to be contacted before the COF is run, the following will occur:
 - Patient will be contacted with their balance due, at which time they may authorize the office to run the COF, or provide another form of payment.
 - If the patient does not respond for **2 weeks**, they will be contacted again with an invoice for the amount due.
 - If the patient does not respond after **4 weeks**, the office will run the card on file.

Payment is authorized by the cardholder on the date listed below for the balance of charges due for procedures received.

- I waive the option to be contacted before the office runs my COF.
- I wish to be contacted before the office runs my COF.

Cardholder Name

Last 4 Digits of Credit Card

Expiration

Billing Zip Code

Signature

Date Signed