DELITEDENTAL

Soudabeh Dehghani, DDS

Credit Card Authorization Form

(Please print out and complete this authorization)

Cardholder Name: _____

Billing Address: _____

Credit card number: _____

Expiration date: _____

Zip code: _____

Dear Patient,

Please, be aware that this information will remain confidential.

We need the information above due to the fact that we do have a strict broken appointment policy that applies especially for longer appointments and appointments on Saturday's and for any past due balance that insurance did not cover for any type of procedures.

We encourage you to keep your scheduled appointments, or to reschedule them in certain amount of time.

With this letter I _____ *am giving an authorization to Delite Dental to charge the cancellation fee or any past due balances from the credit card above.*

Signature: _____ *Date:* _____

818 18th St. NW. LL20 • Washington, DC 20006
t: 202-887-6740 • f: 202-887-8089 • delitedental@gmail.com • www.delitedental.com