Timothy E. Gardner, D.D.S., Ltd., L.L.P.
& Associates
Comprehensive, Cosmetic & Laser Dentistry

Timothy Gardner-D.D.S. Jacob Burch-D.D.S.

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Patient Credit Card Consent for Office Visits & Procedures

Due to continued cuts in reimbursements, the cost of mailing statements and increased postal rates, we ask that you leave a credit card on file for securing any future appointments as well as any unpaid balances for today's visit or any other services not covered by your insurance company.

I hereby authorize Timothy Gardner D.D.S & Associates to keep my signature on file and to charge my credit card for the account balances **not to exceed the billed charge.**

Patient's Names on account: _____
__MasterCard __Visa __Discover __American Express __Carecredit

Card #:_____

Expiration Date: _____ Signature code: _____

Cardholder name as it appears on the card:_____

Cardholder Address:_____

Cardholder phone #: Home_____ Other_____

I understand, any fee(s) quoted to me is an estimate and the actual charges may be higher or lower and will be adjusted upon receipt of the Explanation of Benefits. Please be aware that we must have payment on file prior to the start of your services or your appointment may be rescheduled.

I, the undersigned, certify that I have read the foregoing, I am the patient or duly authorized by the patient as the patient's general/legal agent to execute the above and accept its terms.

_____ _____
Patient Signature **Date**

Choose one:

☐ Please call before running any amount on my card.

☐ Please call before running card if balance is over $_____.

☐ You don't have to call, just run my card for the balance.