



Credit Card Payment Authorization Form for X-Ray/ Records Release

(Do not fill this form if paying by cash)

Patient Name: _____ (print clearly)

I _____ give Zane Dental permission to charge the amount of \$_____
(Full Name of Cardholder)

to the credit card listed below for the cost of X-Ray/Records release of the above named patient. In the event that there are any problems with my credit card payment, I understand the X-Ray/Records will not be released until the problem is resolved.

Account type/ Circle One: Visa MasterCard Discover American Express

Name on Card: _____

Credit Card Number: _____

Credit Card Expiration Date: _____

Card Verification Code (last 3 digits on back of card): _____

Billing Address _____

City, State, Zip _____

Phone # _____

Email _____

I certify that this is my credit card and I am legally authorized to give permission for its use. By completing and signing this agreement, I hereby give my fully informed consent to the duplication of X-Ray/ Records for the above named patient. I understand that once the services have been completed and the payment has been applied, I will not be entitled to any refunds. I agree not to dispute resultant charges.

Cardholder Signature: _____

Date: _____

Cardholder Name: _____

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