BROOKVIEW DENTAL PAYMENT PLAN /AUTO-PAY FORM

Date: _____ Patient Name:

_____Acct#:_____

Total Cost: _____ Total # of Payments: _____

Down Payment: _____ Balance: _____

Monthly Payment: $ _____ 1st Payment Day: _____

Name on Card: _____

Credit Card #:_____

Exp._____ Security Code: _____

I hereby authorize Brookview Dental to charge my Credit Card/Checking Account on the dates listed above. I understand that my card ending in_____ will be ran _____times at $_____ per payment. I understand that this arrangement is only for the balance listed above. If any other treatment or cost is determined, the doctor will propose a new treatment plan and arrangement.

_____ _____

Patient Signature **Date**

_____ _____

Billing Manager Signature **Date**