

Kozlowski Orthodontics, PC  
Jeffrey T. Kozlowski, DDS

Automatic credit/debit card authorization

Patient's name \_\_\_\_\_ Account number \_\_\_\_\_

Card holder's name \_\_\_\_\_

Billing address \_\_\_\_\_

\_\_\_\_\_

Card number \_\_\_\_\_ Code \_\_\_\_\_

Expiration date \_\_\_\_\_ Daytime phone number \_\_\_\_\_

I \_\_\_\_\_ authorize Kozlowski Orthodontics to  
charge my card \$\_\_\_\_\_ for \_\_\_\_\_ months with a final payment of  
\$\_\_\_\_\_, or until my account has been paid in full.

\_\_\_\_\_  
Signature

Date \_\_\_\_\_

\_\_\_\_\_  
Witness

Date \_\_\_\_\_