Credit Card on File Authorization Form

I authorize **Greenlake Family Dentistry** to securely keep my credit card information on file and to charge my card for any balances due after insurance has processed, as well as for any missed appointment fees or services not covered by insurance.

Card Type:

☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

☐ Other: _____

Name on Card: _____

Card Number: _____ **Exp. Date:** _____ **CCV:** _____

Signature: _____ **Date:** _____

Greenlake Family Dentistry
4230 Stone Way N • Seattle, WA 98103
Phone: 206.633.3686 • Fax: 206.633.3695
Email: info@greenlakefd.com
Website: www.greenlakefd.com