Joshua M. Leavitt D.M.D., M.S.
605 Diley Rd. Pickerington, Oh 43147

PEDIATRIC DENTISTRY of Central Ohio

P: (614) 863-8500 | F: (614) 863-0874
office@pdco605.com

Recurring Credit Card Payment Authorization

You authorize regularly scheduled charges to your credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize **Pediatric Dentistry of Central Ohio** to charge my
(Cardholder's Name) (Merchant's Name)

Credit Card indicated below for $_____ on the _____ of
(Amount $) (day)
each _____.
(week, month, etc.)

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Card Details

☐ Visa ☐ MasterCard

Cardholder Name _____
Account/CC Number _____
Expiration Date ____ /____
CVV ____
Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **Pediatric Dentistry of Central Ohio** in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____
(Cardholder's Signature)