DR. JAMES C. MAGESTRO
ORTHODONTIST

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AUTOMATIC CREDIT CARD PAYMENTS

Patient Name _____

name as it appears on credit card	credit card number	expiration date

Address _____

City, State, Zip _____

I authorize monthly payments to be charged to my credit card. The amount to be charged each month is $_____. If any changes are to be made to this amount or to the credit card information, I will contact the office manager by the 15th of the month. Credit card payments will be processed on the 20th of each month or the following Monday if this falls on a weekend.

Signature _____ Date _____