oakwood dental

Credit Card Authorization Form for Dental Office Cancellation Policy

Patient Information:

- **Full Name:** _____
- **Billing Address:** _____
  City, State, ZIP: _____
- **Phone Number:** _____
- **Email Address:** _____

Credit Card Information: (Please note there is a 3.99% fee when using a credit card, this fee is waived when using debit card)

- **Card Type:** □ Visa □ MasterCard □ American Express □ Discover □ Debit Card
- **Card Number:** _____
- **Expiration Date (MM/YY):** _____
- **CVV:** _____

Card Info Verified By: **(office use only)** _____

Authorization for Cancellation Fee: I understand that Oakwood Dental Arts, LLC and its affiliates require at least **24 Hours'** notice for appointment cancellations or rescheduling. Failure to provide this notice will result in a $75 cancellation fee, which will be charged to my credit card on file.

- **Missed or Broken Appointments:**
  A cancellation fee of $75 will be charged to the card on file for any missed or broken appointments outside the practice's cancellation policy of 24 hours in advance.
- **Balances Under $50:**
  I also authorize the practice to charge my card for any outstanding balance under $50 for services rendered, which may include copays and/or other fees that are due immediately.

SMS and Email Communication

Balance notifications will be sent via SMS text and email (pending OPT-IN). Before charging the card on file, you'll receive a reminder that allows you to pay with a different card of choice. Please note that if the balance remains unpaid after 24 hours, we will charge the card on file.

Terms and Conditions:

1. By signing this form, I authorize Oakwood Dental Arts, LLC and its affiliates to charge my credit card for the $75 cancellation fee if I fail to provide the required notice.
2. I certify that I am the authorized holder of this credit card.
3. This authorization will remain in effect until I provide written notice of cancellation of this agreement and/or card.
4. I understand that this policy helps the dental office manage its schedule effectively and ensure availability for all patients.
5. Disputes regarding charges are subject to the terms of Oakwood Dental and applicable state laws in NY and NJ.
6. I understand, if the card provided Is not a debit card, there is an additional 3.99% service charge for all transactions.

Cardholder Signature: I agree to the terms and conditions outlined above and authorize this charge to my credit card.

- **Cardholder Signature:** _____
- **Date:** _____

Confidentiality:
This information will be kept confidential and secure in accordance with applicable laws and regulations.