Ligon Dental Group
5201 Central Avenue
Saint Petersburg, FL 33710
727-321-7880

# Credit Card Authorization Form

I authorize **Ligon Dental Group** to charge my credit card as indicated below:

____ Please keep this signature on file for any estimated portion due at the time of service and any unpaid balance after insurance payment.

____ I authorize Ligon Dental Group to charge my card as indicated below.

Balance ________________

Date ________________ Payment of ________________ on the specific dates.

Date ________________ Date ________________

Patient name ________________________________________________

Responsible Party ________________________________________________

Address ________________________________________________

________________________________________________

Phone Number ________________________________________________

**Visa - Mastercard - Discover - American Express**

Card Number ________________________________________________

Exp Date ________________________ CVV Code ______________________

Card Holder Signature ________________________________________________

Printed Name ________________________________________________

Staff Initials ___________