Credit Card Authorization

I, _____ authorize Dr. Brett R. Warn to charge my credit/debit card to cover any fees **NOT** paid by my insurance company. I understand this credit/debit card will be collected to reserve appointments on the schedule and that any appointment cancelled without ***48 hours*** notice is subject to a $100 non-cancellation fee.

Dental Insurance plans have gotten so complex that no dentist can ESTIMATE COVERAGE EXACTLY. After payment is received from your insurance company, if you still owe any additional co-payment, we will automatically bill your credit card for the additional amount due. More importantly, we will credit you immediately if your insurance paid more than expected.

Card Type:_____ Credit Card #: _____

Name as it appears on credit card: _____

Expiration Date: _____ CVV#:_____ (three digit code on card/AMEX has 4 digit code)

Address used for billing statement of credit card:

_____

_____ ZIP_____

Card Holder's Signature: _____

Name(s) of Family Members covered: _____

_____

**Notification requested _____ (only if over $100)

We accept Visa, Mastercard, Discover, American Express, Care Credit

Brett R Warn DDS, 5103 NW Cache Road Lawton OK 73505 (580)-248-4224