LAWRENCE E. BRECHT, D.D.S., P.C.
DEBRA H. COHN, D.D.S.

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Authorized Credit Card Payment Form

I authorize **Dr. Lawrence E. Brecht. D.D.S., P.C. and Dr. Debra H. Cohn, D.D.S., P.C.** to keep my signature on file *and* to charge my Mastercard, Visa or American Express account as indicated below:

Check One: ____Mastercard _____Visa _____American Express

___The balance due on my account $_____

___Recurring charges (on-going treatments) of $_____every_____from_____
(frequency) (date)

to_____.
(date)

Account Number - _____ **Security Code**:_____
(last 3 digits on back of card)

Expiration Date - _____
(Month) (Year)

Cardholder's Signature:_____ **Today's date:_____**

Cardholder's Name as it appears on card: _____

Cardholder's Billing Address: _____

City:_____**State**:_____**Zip**:_____

Home Telephone: (_____) _____(include area code)

Work Telephone: (_____) _____(include area code)