POPE FAMILY DENTISTRY
MEMBER

Date _____

POPE FAMILY DENTISTRY MEMBERSHIP PLAN PAYMENT FORM

Payment Totals

_____ @ $300 _____ @ $250 _____ @ $150 _____ **Total**

Payment Options (please mark one)

____ **1 time pay in full** ____ **3 recurring monthly payments** ____ **6 recurring monthly payments**

Card Information

Name as appears on credit card_____

Type of card: ____Visa ____MasterCard ____AMEX ____Discover ____Other_____

Card number _____ Exp Date (mm/yy)_____

Billing Address Zip Code_____ 3 digit security code _____

Authorization

I, _____, authorize Pope Family Dentistry to charge my above credit card for the agreed upon amounts. I also give permission for recurring payments as agreed upon above, and I understand that my information will be saved on file for future transactions on my account.

Signature _____ Date _____