



Date _____

POPE FAMILY DENTISTRY MEMBERSHIP PLAN PAYMENT FORM

Payment Totals

_____ @ \$325 _____ @ \$275 _____ @ \$200 _____ **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 _____