

# carolina dental arts

**In order to accept assignment of benefits, we now require that a credit/debit card be left on file with our office.**

I authorize Dr. Kyle Roth & Associates to keep my signature on file and to charge my credit/debit card account for:

- Balance of charges not paid by Insurance within 60 days and not to exceed \$50.00. We will call on all balances over \$50.00 for authorization before charging your credit card.
- Any overpayment on the account will be refunded to the same credit card I use for payment.

I assign my insurance benefits to the provider listed above. I understand this form is valid unless I cancel the authorization through written notice to Dr. Kyle Roth and provide alternative payment for committed amount. I understand that this credit card information will not be shared with any outside sources.

Patient Name: _____	
Cardholder Name: _____	Home Phone: _____
Cardholder Address: _____	Cell Phone: _____
City, State, Zip: _____	

Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

3 Digit Security Code (on signature block): \_\_\_\_\_

Please choose one: Visa / Mastercard / Discover

Cardholder Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_